N.J.A.C. TITLE 8
CHAPTER 43H

Licensing Standards For REHABILITATION HOSPITALS

Authority
N.J.S.A. 26:2H-1 et seq.

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New Jersey Department of Health and Senior Services
Division of Health Care System Analysis
Certificate of Need and Acute Care Licensure Program

REHABILITATION HOSPITAL LICENSING STANDARDS
N.J.A.C. 8:43H
TABLE OF CONTENTS

REHABILITATION HOSPITAL LICENSING STANDARDS
N.J.A.C. 8:43H
TABLE OF CONTENTS
(Continued)

SUBCHAPTER 1. DEFINITIONS AND QUALIFICATIONS

8:43H-1.1 Scope

The rules in this chapter pertain to all facilities which provide comprehensive rehabilitation services, including hospitals which provide these services as a separate service. These rules constitute the basis for the licensure of rehabilitation hospitals by the New Jersey State Department of Health and Senior Services.

8:43H-1.2 Purpose

Rehabilitation hospitals provide integrated care to disabled individuals in order to assist these individuals in reaching the functional levels of which they are capable as well as to protect their health and safety. The aim of this chapter is to establish minimum rules to which a rehabilitation hospital must adhere in order to obtain a license to operate in New Jersey.

8:43H-1.3 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Activities of daily living (ADL)" means the functions or tasks for self-care which are performed either independently or with supervision or assistance. Activities of daily living include at least: mobility, transferring, walking, grooming, bathing, dressing and undressing, eating, and toileting.

"Adult patient" means a patient who is 20 years of age or older. A pediatric rehabilitation hospital may treat an adult patient who is 20 years of age or older as long as the patient or the patient's legal guardian has indicated permission and it is documented that he or she has been informed of the availability of an adult rehabilitation hospital.

"Ancillary nursing personnel" means unlicensed workers employed to assist licensed nursing personnel.

"Available" means ready for immediate use (pertaining to equipment) or capable of being reached (pertaining to personnel), unless otherwise defined.

"Bylaws" means a set of rules adopted by the facility for governing its operation. A charter, articles of incorporation, and/or a statement of policies and objectives is an acceptable equivalent.

"Cleaning" means the removal by scrubbing and washing, as with hot water, soap or detergent, and vacuuming, of infectious agents and of organic matter from surfaces on which and in which infectious agents may find conditions for surviving or multiplying.

"Clinical note" means a written, signed, and dated notation made by each health care professional who renders a service to the patient.

"Commissioner" means the New Jersey State Commissioner of Health and Senior Services.

"Communicable disease" means an illness due to a specific infectious agent or its toxic products, which occurs through transmission of that agent or its products from a reservoir to a susceptible host.

"Conspicuously posted" means placed at wheelchair height at a location within the facility accessible to and seen by patients and the public.

"Contamination" means the presence of an infectious or toxic agent in the air, on a body surface, or on or in clothes, bedding, instruments, dressings, or other inanimate articles or substances, including water, milk, and food.

"Controlled Dangerous Substances Acts" means the Controlled Substances Act of 1970 (Title II, Public Law 91-513) and the New Jersey Controlled Dangerous Substances Act of 1970 (N.J.S.A. 24:21-1 et seq.).

"Current" means up-to-date, extending to the present time.

"Department" means the New Jersey State Department of Health and Senior Services.

"Discharge plan" means a written plan initiated within 24 hours of the patient's admission, which includes at least an evaluation of the patient's needs, the development of goals for discharge, and referrals to community agencies and resources for services following discharge.

"Disinfection" means the killing of infectious agents outside the body, or organisms transmitting such agents, by chemical and physical means, directly applied. The term "disinfection" includes concurrent disinfection; that is, the application of measures of disinfection as soon as possible after the discharge of infectious material from the body of an infected person, or after the soiling of articles with such infectious discharges, all personal contact with such discharges or articles being minimized prior to such disinfection. The term "disinfection" also includes post care disinfection, which is the application of measures of disinfection after the patient has ceased to be a source of infection.

"Documented" means written, signed, and dated.

"Drug" means a substance as defined in the New Jersey State Board of Pharmacy Rules, N.J.A.C. 13:39. The word "medication" is used interchangeably with the word "drug" in this chapter.

"Drug administration" means a procedure in which a prescribed drug or biological is given to a patient by an authorized person in accordance with all laws and rules governing such procedures including all of the following:

1. Removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container);

2. Verifying the individual dose with the prescriber's orders;

3. Giving the individual dose to the patient;

4. Seeing that the patient takes the individual does (if oral); and

5. Recording the name and strength of the drug, date and time of administration, dosage administered, method of administration, and signature of the person administering the drug.

"Drug dispensing" means a procedure entailing the interpretation of the original or direct copy of the prescriber's order for a drug and, pursuant to that order, the proper selection, measuring, labeling, packaging, and issuance of the drug to a patient or a service or unit of the facility, in conformance with all applicable Federal, State, and local rules and regulations.

"Environmental assessment services" means a process of evaluation of a patient's living environment as may be needed to permit maximum independent functioning.

"Environmental modification services" means a process of evaluation and/or adaptation of a patient's living environment as may be needed to permit maximum independent functioning.

"Epidemic" means the occurrence in a facility of one or more cases of an illness in excess of normal expectancy for that illness, and derived from a common or propagated source.

"Family" means persons related by blood, marriage, or commitment.

"Full-time" means relating to a time period established by the facility as a full working week, as defined and specified in the facility's policies and procedures.

"Governing authority" means the organization, person, or persons designated to assume legal responsibility for the management, operation, and financial viability of the facility.

"Health care facility" means a facility so defined in N.J.S.A. 26:2H-1 et seq., and amendments thereto.

"Hospital" means a health care facility as defined in N.J.A.C. 8:43B.

"Interdisciplinary care plan" means a written, individualized plan of care for each patient, developed by the interdisciplinary team members participating in the patient's care, and based upon their assessment and plans for rehabilitation interventions.

"Interdisciplinary team" means, at a minimum, individual representatives from medicine, nursing, rehabilitation and social work/case management shall work together to plan, provide and evaluate a comprehensive, integrated program of care to the patient.

"Intravenous infusion admixture service" means the preparation by pharmacy personnel of intravenous infusion solutions requiring compounding and/or reconstitution.

"Job description" means written specifications developed for each position in the facility, containing the qualifications, duties and responsibilities, and accountability required of employees in that position.

"Licensed nursing personnel" (licensed nurse) means registered professional nurses and practical (vocational) nurses licensed by the New Jersey Board of Nursing pursuant to N.J.S.A. 45:11-23 et seq. and N.J.A.C. 13:37.

"Medical record" means all records in the facility which pertain to the patient, including radiological films.

"Monitor" means to observe, watch, or check.

"Nosocomial infection" means an infection that develops in a patient during hospitalization and is not present or incubating at the time of admission to the hospital.

"Nursing unit" means a continuous area on one floor, which includes rooms for patients.

"Pediatric patient" means a patient who is under 20 years of age. An adult rehabilitation hospital may treat a pediatric patient who is 16 to 20 years of age as long as the patient or the patient's legal guardian has indicated permission and it is documented that he or she has been informed of the availability of a pediatric rehabilitation hospital.

"Physician progress note" means a written, signed, and dated notation in the medical record by the physician providing care within 48 hours of care provision.

"Prescriber" means a person who is authorized to write prescriptions in accordance with Federal and State laws.

"Progress note" means a written, signed, and dated notation summarizing information about health care provided and the patient's response to it.

"Rehabilitation hospital" means a facility licensed by the New Jersey State Department of Health and Senior Services to provide comprehensive rehabilitation services to patients for the alleviation or amelioration of the disabling effects of illness. Comprehensive rehabilitation

services are characterized by the coordinated delivery of interdisciplinary care intended to achieve the goal of maximizing the independence of the patient. A rehabilitation hospital is a facility licensed to provide only comprehensive rehabilitation services or is a distinct unit providing only comprehensive rehabilitation services located in a licensed health care facility.

"Restraint" means a physical device or chemical (drug) used to limit, restrict, or control patient movements and not associated with therapeutic interventions or protocols.

"Self-administration" means a procedure in which any medication is taken orally, injected, inserted, or topically or otherwise administered by a patient to himself or herself.

"Shift" means a time period defined as a full working day by the facility in its policy manual.

"Signature" means at least the first initial and full surname and title (for example, R.N., L.P.N., D.D.S., M.D.) of a person, legibly written either with his or her own hand, generated by computer with authorization safeguards, or communicated by a facsimile communications system (FAX), and any other information required by a professional licensing board.

"Staff education plan" means a written plan developed at least annually and implemented throughout the year which describes a coordinated program for staff education for each service, including inservice programs and on-the-job training.

"Staff orientation plan" means a written plan for the orientation of each new employee to the duties and responsibilities of the service to which he or she has been assigned, as well as to the personnel policies of the facility.

"Sterilization" means a process of destroying all microorganisms, including those bearing spores, in, on, and around an object.

"Supervision" means authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his or her sphere of competence, with initial direction and periodic on-site inspection of the actual act of accomplishing the function or activity.

"Unit dose drug distribution system" means a system in which drugs are delivered to patient areas in single unit packaging. Each patient has his or her own receptacle, such as a tray, bin, box, cassette, drawer, or compartment, labeled with his or her first and last name and room number, and containing his or her own medications. Each medication is individually wrapped and labeled with the generic name, trade name (if appropriate), and strength of the drug, lot number or reference code, expiration date, and manufacturer's or distributor's name, and ready for administration to the patient.

8:43H-1.4 Qualifications of the operations manager accountable for rehabilitation services

The operations manager accountable for rehabilitation services shall have a baccalaureate degree in administration or in a health care discipline and four years of administrative or supervisory experience in a health care facility.

8:43H-1.5 Qualifications of audiologists

Each audiologist shall be so licensed by the Division of Consumer Affairs of the New Jersey State Department of Law and Public Safety pursuant to N.J.S.A. 45:3B-1 et seq. and N.J.A.C. 13:44C.

8:43H-1.6 Qualifications of case managers

Each case manager shall be either a certified case manager, a registered professional nurse or a certified social worker.

8:43H-1.7 Qualifications of dentists

Each dentist shall be so licensed by the New Jersey State Board of Dentistry, pursuant to N.J.S.A. 45:6-1 et seq. and N.J.A.C. 13:30.

8:43H-1.8 Qualifications of dietitians

(a) Each dietitian shall:

1. Be registered or eligible for registration by the Commission on Dietetic Registration of the American Dietetic Association;

2. Have a bachelor's degree from a college or university with a major in foods, nutrition, food service or institution management, or the equivalent course work for a major in the subject area, and:

i. Have completed a dietetic internship accredited by the American Dietetic Association or a dietetic traineeship approved by the American Dietetic Association; or

ii. Have one year of full-time, or full-time equivalent, experience in nutrition and/or food service management in a health care setting; or

3. Have a master's degree plus six months of full-time, or full-time equivalent, experience in nutrition and/or food service management in a health care setting.

8:43H-1.9 Qualifications of the nurse accountable for rehabilitation nursing services

The nurse accountable for rehabilitation nursing services shall be a registered professional nurse who has completed a masters degree program in a health related and/or business field, has at least two years of full-time, or full-time equivalent, experience in nursing supervision and/or nursing administration in a health care facility and, within two years of appointment, shall be eligible to be certified as a registered rehabilitation nurse (CRRN).

8:43H-1.10 Qualifications of food service supervisors

(a) Each food service supervisor shall:

1. Be a dietitian; or

2. Be a graduate of a dietetic technician or dietetic assistant training program approved by the American Dietetic Association; or

3. Be a graduate of a course, approved by the New Jersey State Department of Education, providing 90 or more hours of classroom instruction in food service supervision, and have one year of full-time, or full-time equivalent, experience as a food service supervisor in a health care facility, with consultation from a dietitian; or

4. Have training and experience in food service supervision and management in a military service equivalent to the programs listed in (a)2 or 3 above.

8:43H-1.11 Qualifications of licensed practical nurses

Each licensed practical nurse shall be so licensed by the New Jersey Board of Nursing pursuant to N.J.S.A. 45:11-23 et seq. and N.J.A.C. 13:37.

8:43H-1.12 Qualifications of the medical director

The medical director shall be a physiatrist who is certified by the American Board of Physical Medicine and Rehabilitation, Inc., or the American Osteopathic Board of Rehabilitation Medicine. If the facility provides services to pediatric patients primarily, the medical director may be a pediatrician who is certified by the American Board of Pediatrics, Inc., or the American Osteopathic Board of Pediatrics.

8:43H-1.13 Qualifications of medical records practitioners

(a) Each medical record practitioner shall:

1. Be eligible for certification as a registered record administrator (RRA) or an accredited record technician (ART) by the American Medical Record Association; or

2. Be a graduate of a program in medical record science accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association in collaboration with the Council on Education of the American Medical Record Association.

8:43H-1.14 Qualifications of occupational therapists

"Occupational therapist" means a person who is licensed as an occupational therapist by the Occupational Therapy Advisory Council pursuant to N.J.S.A. 45:9-37.51 et seq. and N.J.A.C. 13:44K.

8:43H-1.15 Qualifications of pediatricians

Each pediatrician shall be a physician who is certified or eligible for certification by the American Board of Pediatrics, Inc., or the American Osteopathic Board of Pediatrics.

8:43H-1.16 Qualifications of pharmacists

Each pharmacist shall be so registered by the New Jersey State Board of Pharmacy, pursuant to N.J.S.A. 45:14-1 et seq. and N.J.A.C. 13:39.

8:43H-1.17 Qualifications of physiatrists

Each physiatrist shall be a physician who is certified or eligible for certification by the American Board of Physical Medicine and Rehabilitation, Inc., or the American Osteopathic Board of Rehabilitation Medicine.

8:43H-1.18 Qualifications of physical therapists

"Physical therapist" means a person who is so licensed by the New Jersey State Board of Physical Therapy pursuant to N.J.S.A. 45:9-37.12 et seq. and N.J.A.C. 13:39A et seq.

8:43H-1.19 Qualifications of physicians

Each physician shall be licensed or authorized by the New Jersey State Board of Medical Examiners, pursuant to N.J.S.A. 45:9-1 et seq. and N.J.A.C. 13:35, to practice medicine in the State of New Jersey.

8:43H-1.20 Qualifications of psychologists

Each psychologist shall be so licensed by the New Jersey State Board of Psychological Examiners, pursuant to N.J.S.A. 45:14B-1 et seq. and N.J.A.C. 13:42, unless the facility has obtained the appropriate waiver.

8:43H-1.21 Qualifications of the individual overseeing therapeutic recreation

(a) The individual overseeing therapeutic recreation shall be a Certified Therapeutic Recreation Specialist (CTRS) certified by the National Council for Therapeutic Recreation Certification (NCTRC), and:

1. Have a bachelor's degree from an accredited college with a major in therapeutic recreation or recreational therapy; or

2. Have five years of full- time, or full-time equivalent, experience in therapeutic recreation.

8:43H-1.22 Qualifications of registered professional nurses

"Registered professional nurse" means a person who is so licensed by the New Jersey Board of Nursing pursuant to N.J.S.A. 45:11-23 et seq. and N.J.A.C. 13:37.

8:43H-1.23 Qualifications of respiratory therapists

Each respiratory therapist shall be certified or eligible for certification by the National Board for Respiratory Care.

8:43H-1.24 Qualifications of social workers

Each social worker providing direct social work services shall be licensed by the Division of Consumer Affairs of the New Jersey Department of Law and Public Safety, pursuant to N.J.S.A. 45:15BB-1 et seq. and N.J.A.C. 13:44G. If the facility has a director of social services, that individual shall be licensed by the Division of Consumer Affairs of the New Jersey Department of Law and Public Safety and have at least one year of post-master's social work experience in a health care setting in accordance with N.J.S.A. 45:15BB-1 et seq.

8:43H-1.25 Qualifications of speech-language pathologists

"Speech-language pathologist" means a person who is so licensed by the Audiology and Speech Language Pathology Advisory Committee of the Division of Consumer Affairs of the New Jersey State Department of Law and Public Safety pursuant to N.J.S.A. 45:3B-1 et seq. and N.J.A.C. 13:44C.

SUBCHAPTER 2. LICENSURE AND LICENSURE PROCEDURES

8:43H-2.1 Certificate of Need

(a) According to N.J.S.A. 26:2H-1 et seq., and amendments thereto, a health care facility shall not be instituted, constructed, expanded, or licensed to operate except upon application for and receipt of a Certificate of Need issued by the Commissioner.

(b) Application forms for a Certificate of Need and instructions for completion may be obtained from:

Director
Certificate of Need and Acute Care Licensure Program
New Jersey State Department of Health and Senior Services
PO Box 360, Room 403
Trenton, NJ 08625

(c) The facility shall implement all conditions imposed by the Commissioner as specified in the Certificate of Need approval letter. Failure to implement the conditions may result in the imposition of sanctions in accordance with N.J.S.A. 26:2H-1 et seq., and amendments thereto.

8:43H-2.2 Suitability review

(a) An applicant for rehabilitation hospital licensure may voluntarily seek guidance and consultation from the Department concerning proper implementation of licensure requirements and/or a preliminary determination of whether a proposed facility or service complies with applicable licensure standards, including, but not limited to, the provisions contained in this chapter.

(b) Requests for a suitability review shall be in writing, specifying the type of facility and/or service proposed, and shall be forwarded to:

Director
Certificate of Need and Acute Care Licensure
NJ Department of Health and Senior Services
PO Box 360, Room 403
Trenton, New Jersey 08625-0360

(c) There shall be no fee charged for suitability review.

8:43H-2.3 Suitability review procedure

(a) Applications for suitability review shall include the following, as applicable:

1. A description of the project, including location and time frame for implementation;

2. Projected staffing levels and staff qualifications;

3. A physical plant description and floor plans with dimensions;

4 A statement that the applicant understands and will comply with all operational licensing and physical plant requirements;

5. Requests for waivers to operational licensing and physical plant requirements as permitted, including all arguments that would support approval of the request at N.J.A.C. 8:42C-2.6;

6. A list of the names, locations, types and Medicare provider numbers, where applicable, of all licensed health care facilities operated or managed by the applicant or any principals, in New Jersey and, in the care of new licensees, in all other states;

7. The licensure application information required at N.J.A.C. 8:43H-2.5 where applicable;

8. Other information determined by the applicant to be necessary and appropriate for the Department's consideration.

(b) The Department shall complete the suitability review within 60 days of the request following receipt of a complete application.

1. If an application is incomplete, the Department shall provide notice to the applicant of any deficiencies in the application. The applicant may resubmit the application or add corrections to the application at any time.

2. Following review of a complete application, the Department shall provide to the applicant a written determination either approving or denying the suitability of the proposed project, together with the reasons therefore and any limitation or conditions of future licensure approval, where applicable. In cases where the applicant has so requested, the determination shall also contain the Department's assessment of waiverability of any otherwise applicable licensure standard.

8:43H-2.4 Suitability review approval

(a) Suitability review approval shall remain in effect for a period of two years from the date of approval.

(b) Notwithstanding any of the provisions as set forth in this chapter, suitability review approval is advisory only and shall not be construed as a guarantee of eventual licensure approval in any case.

(c) Notwithstanding any of the provisions as set forth in this chapter, in order to obtain a license, every facility and/or service shall comply with applicable licensure standards in N.J.A.C. 8:43H-2.5, and at all times thereafter.

8:43H-2.5 Licensure application

(a) The applicant shall submit to the Department a nonrefundable fee of $8,000 for the filing of an application for licensure of a rehabilitation hospital and a nonrefundable $8,000.00 for the annual renewal of the license. First time licensure applicants shall pay both the new facility fee and the nonrefundable biennial inspection fee of $4,000 upon filing an application. Renewal applicants will be subject to the biennial fee in accordance with the Department's inspection schedule.

(b) All applicants must demonstrate character and competence, the ability to provide quality of care commensurate with applicable licensure standards, and an acceptable track record of past and current compliance with in-and out-of- State licensure requirements for new licenses, as applicable, and Federal requirements, as applicable, including, but not limited to the following:

1. The performance of the applicant in meeting its obligations under any previously approved New Jersey certificate of need, where applicable, including full compliance with all conditions of approval, if applicable; and

2. The capacity to provide quality care which meets or surpasses the requirements contained in applicable licensure standards pertinent to the proposed facility and/or service, as set forth below:

i. Applicants shall demonstrate a satisfactory record of compliance with licensure standards in existing health care facilities which are owned, operated, or managed, in whole or in part, by the applicant, according to the provisions in (h) below. In addition to demonstrating compliance with in- State licensure provisions, applicants must also include reports issued by licensing agencies in other states, where applicable;

ii. Applicants shall include narrative descriptions of staffing patterns, policies and protocols addressing delivery of nursing, medical, pharmacy, dietary, and other services affecting quality of care to patients; and

iii. Applicants shall include documentation of compliance with the standards of accreditation of nationally-recognized professional bodies.

(c) The Department shall examine and evaluate the licensure track record of each applicant for the period beginning 12 months preceding the submission of the application and extending to the date on which a determination is made either to approve or deny the license, for the purpose of determining the capacity of an applicant to operate a health care facility in a safe and effective manner, in accordance with State and Federal requirements. An application for a license may be denied where an applicant has not demonstrated such capacity, as evidenced by continuing violations, a pattern of violations of State licensure standards or Federal conditions of participation standards, or existence of a criminal conviction or a plea of guilty to a charge of fraud, patient or resident abuse or neglect, or crime of violence or moral turpitude. An application may also be denied where an applicant has violated any State licensing or Federal certification standards in connection with an inappropriate discharge or denial of admission of a patient. An applicant, for purposes of this section, includes any person who was or is an owner or principal of a licensed health care facility, excluding individuals or entities who are limited partners with no managerial control or authority over the operation of the facility and who have an ownership interest of 10 percent or less in a corporation which is the applicant and who also do not serve as officers or directors of the applicant corporation.

(d) An applicant for a new license who operates or manages licensed or Federally certified health care facilities in other states, shall have performed an evaluation of each facility's compliance with state and Federal licensing and certification requirements during the 12 months preceding application submission and extending to the date on which a determination is made to either approve or deny the license. This information shall be submitted on the letterhead of the state agency responsible for health facility inspection, monitoring, and enforcement of state and Federal requirements. The following information shall be included:

1. Written notice that the subject facilities have been in substantial compliance with licensing and/or certification requirements during the 12 months immediately preceding application submission; and

2. In instances in which substantial compliance has not been achieved, a description of the deficiency or deficiencies and a description of penalties and other enforcement action imposed by the state agency and/or imposed by, or recommended to the Health Care Financing Administration.

(e) An applicant for license who was cited for any state licensure or Federal certification deficiency during the period identified in (c) and (d) above, which presented a serious risk to the life, safety, or quality of care of the facility's patients or residents, shall be denied, except in cases where the applicant has owned/operated the facility for less than 12 months and the deficiencies occurred during the tenure of the previous owner/operator. In any facility, the existence of a track record violation during the period identified in (c) and (d) above shall create a rebuttable presumption, which may be overcome as set forth below in this subsection, that the applicant is unable to meet or surpass licensure standards of the State of New Jersey. Those applicants with track record violations which would result in denial of the application shall submit with their application any evidence indicating that the track record violations do not presage operational difficulties and quality of care violations at the facility which is the subject of the application or in any other licensed facility in New Jersey, which is operated or managed

by the applicant. If after review of the application and the evidence submitted to rebut a negative track record, the Commissioner denies the application, the applicant may request a hearing which will be held in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1.1. At the Commissioner's discretion, the hearing shall be conducted by the Commissioner or transferred to the Office of Administrative Law. The purpose of the hearing is to provide the applicant with the opportunity to present additional evidence in conjunction with evidence already included with the initial application, for the purpose of demonstrating the applicant's operational history and capacity to deliver quality of care to patients or residents which meets or surpasses licensure standards of the State of New Jersey to the satisfaction of the Commissioner or his or her designee. The conclusion of that process with either a decision by the Commissioner, or the Commissioner's acceptance or denial of an initial decision by an administrative law judge, shall constitute a final agency decision. A serious risk to life, safety, or quality of care of patients or residents includes, but is not limited to, any deficiency in State licensure or Federal conditions of participation requirements (42 C.F.R. 488.400) resulting in:

1. An action by a state or Federal agency to ban, curtail or temporarily suspend admissions to a facility or to suspend or revoke a facility's license; or

2. A termination, or exclusion from Medicaid, or Medicare participation, including denial of payment for new admissions, imposed by the Department or by the Health Care Financing Administration, as a result of noncompliance with Medicaid or Medicare conditions of participation.

(f) The criteria for denial of an application specified in (c) through (e) above shall also result in denial of a new license if the criteria are found to have been true of the lower of five facilities or five percent of out-of-State facilities operated or managed by the applicant, within the 12 months preceding submission of the application and extending to the date on which a determination is made to either approve or deny the license and with respect to any service which is similar or related to the proposed service.

(g) In addition to the provisions of (c) through (e) above, and notwithstanding any express or implied limitations contained therein, the Commissioner or Commissioner's designee may deny any application where he or she determines that the actions of the applicant at any facility operated or managed by the applicant constitute a threat to the life, safety, or quality of care of the patients or residents. In exercising his or her discretion under this subsection, the Commissioner shall consider the following:

1. The scope and severity of the threat;

2. The frequency of occurrence;

3. The presence or absence of attempts at remedial action by the applicant;

4. The existence of any citations, penalties, warnings, or other enforcement actions by any governmental entity pertinent to the condition giving rise to the threat;

5. The similarity between the service within which the threat arose and the service which is the subject of the application; and

6. Any other factor which the Commissioner deems to be relevant to assessment of risk presented to patients or residents.

(h) For the purposes of this section, comprehensive rehabilitation care shall be considered similar to the acute care category which includes hospital services such as medical/surgical, pediatric, cardiac, psychiatric, intensive care/critical care, surgical services, magnetic resonance imaging and computerized tomography, lithotripsy, renal dialysis, obstetric, and birth centers.

(i) Each rehabilitation hospital shall be assessed a nonrefundable biennial inspection fee of $4,000. For existing facilities, this fee shall be assessed in the year the facility will be inspected, along with the annual licensure fee for that year. The fee shall be added to the initial licensing fee for new facilities. Failure to pay the inspection fee shall result in non-renewal of the license for existing facilities and the refusal to issue an initial license for new facilities. This fee shall be imposed only every other year even if inspections occur more frequently and only for the inspection required to either issue an initial license or to renew an existing license. This fee shall not be imposed for any other type of inspection.

8:43H-2.6 Licensure

(a) A license shall be issued if surveys by the Department have determined that the rehabilitation hospital is being operated as required by N.J.S.A. 26:2H-1 et seq. and amendments thereto, and by this chapter.

(b) At the request of the applicant, an office conference for review of the conditions for licensure and operation may take place between Certificate of Need and Acute Care Licensing Program representatives within the Department and the applicant, who shall be advised that the purpose of the conference is to allow the Department to determine whether the applicant complies with this chapter.

(c) When the written application for licensure has been submitted and the building is ready for occupancy and/or use, a survey of the facility by representatives of the Department shall be conducted to determine if the facility complies with the pertinent licensure rules. Applicants shall provide the Department's Inspection, Complaints and Compliance Program with at least 45 days notice of the date they want the survey to occur.

(d) Subsequent survey visits may be made to a rehabilitation hospital any time, or to a patient's home with the patient's consent, by authorized staff of the Department. Such visits may include, but not be limited to, a review of all facility documents and patient records, and conferences with patients and/or their families.

(e) Surveys shall be conducted, deficiencies reported, disputes resolved, and plans of correction submitted in accordance with N.J.A.C. 8:43E-2.

(f) A license shall be issued to a rehabilitation hospital for a period of one year when the following conditions are met:

1. Written approvals are on file with the Department from the local zoning, fire, health, and building authorities, or a certificate of occupancy or a certificate of continued occupancy has been issued by the local municipality; and

2. Survey(s) by representatives of the Department indicate that the rehabilitation hospital complies with the pertinent licensure rules.

(g) The license shall be conspicuously posted at the rehabilitation hospital.

(h) No rehabilitation hospital shall accept patients until the facility has the written approval and/or license issued by the Department.

(i) Except as set forth below, the license is not assignable or transferable, and it shall be immediately void if the rehabilitation hospital ceases to operate, if the rehabilitation hospital ownership changes, if the rehabilitation hospital is relocated to a different site, or if a component part of a rehabilitation hospital ceases to operate.

1. If the rehabilitation hospital or a component thereof ceases to operate, the licensee may request that the Department maintain the license for a period of up to 24 months. The licensee shall make such a request at least 30 days prior to ceasing operations, and such request shall include the rationale and the timeframe for the extension.

2. In the case of a transfer of ownership, new owners of a rehabilitation hospital shall make application for licensure with the Department, in accordance with the provisions as set forth in N.J.A.C. 8:43H-2.1 and this subchapter. In addition, the following information shall be submitted with the application:

i. A description of the proposed transfer of ownership, in detail, including total purchase cost;

ii. Identification of 100 percent of the current and prospective ownership of both the physical assets of the comprehensive rehabilitation hospital and the operation of the comprehensive rehabilitation hospital;

iii. Where applicable, 100 percent of the ownership of leased buildings and property; and

iv. Copies of all legal documents pertinent to the transfer of ownership transaction which are signed by both the current licensed owners and the proposed licensed owners.

(j) The license, unless suspended or revoked, shall be renewed annually on the original licensure date, or within 30 days thereafter but dated as of the original licensure date. The rehabilitation hospital will receive a request for renewal fee 30 days prior to the expiration of the license. A renewal license shall not be issued unless the licensure fee is received by the Department.

(k) The license may not be renewed, if State licensing standards, local rules, regulations, and/or requirements are not met.

(l) Failure to renew a license shall constitute operation of a health care facility without a license and may result in issuance by the Department of a cease and desist order, in accordance with N.J.A.C. 8:43E-3.11 and other penalties in accordance with N.J.A.C. 8:43E-3.4(a)l.

(m) To qualify for licensure as a new freestanding rehabilitation hospital, the minimum bed size required is 60 beds. To qualify for licensure as a licensed health care facility-based comprehensive rehabilitation unit, the minimum bed size required is 30 beds.

(n) To maintain licensure as an adult rehabilitation hospital or unit, 75 percent of patient days annually must fall into the following diagnostic categories:

1. Stroke;
2. Spinal cord injury;
3. Congenital deformity;
4. Amputation;
5. Major multiple trauma;
6. Fractures of femur;
7. Brain injury;
8. Burns;
9. Polyarthritis, including rheumatoid arthritis; and
10. Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.

(o) To maintain licensure as a pediatric rehabilitation hospital/ unit, 75 percent of patient days annually must fall into the following diagnostic categories:

1. Stroke;

2. Spinal cord injury;

3. Congenital deformity;

4. Amputation;

5. Major multiple trauma;

6. Fractures of femur;

7. Brain injury;

8. Burns;

9. Polyarthritis, including rheumatoid arthritis; and

10. Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.

(p) To qualify for licensure as a rehabilitation hospital or rehabilitation unit located in a licensed health care facility, the following are required:

1. All staff shall have documented competencies in rehabilitation in accordance with facility policies;

2. A unit shall have a registered professional nurse assigned solely to each unit at all times; and

3. During each 24-hour period, at least 50 percent of all other licensed and unlicensed nursing personnel shall be individuals who are assigned solely to the rehabilitation service and who do not float from non-rehabilitation units or agencies.

8:43H-2.7 Surrender of license

(a) A rehabilitation hospital which intends to close voluntarily and to cease delivery of services shall notify the Department's Certificate of Need and Acute Care Licensure Program in writing a minimum of 30 days in advance. A plan for closure shall be developed which provides for the orderly transfer of patients to another rehabilitation hospital of their choice. Such plan shall also be submitted to the Department a minimum of 30 days prior to closure or cessation of service delivery.

(b) The rehabilitation hospital shall notify each patient, resident, or client, their physicians, and any guarantors of payment at least 30 days prior to the voluntary surrender of a license, or as directed under an order of revocation, refusal to renew, or suspension of license. In such cases, the license shall be returned to the Department within seven working days after the voluntary surrender, non-renewal, or suspension of license.

8:43H-2.8 Waiver

(a) The Commissioner or his or her designee may, in accordance with the general purposes and intent of this chapter, waive sections of the rules if, in his or her opinion, such waiver would not endanger the life, safety, or health of patients or the public.

(b) A rehabilitation hospital seeking a waiver of these rules shall apply in writing to the Director of the Certificate of Need and Acute Care Licensure Program of the Department.

(c) A written request for waiver shall include the following:

1. The specific rule(s) or part(s) of the rule(s) for which waiver is requested;

2. Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the facility upon full compliance;

3. An alternative proposal which would ensure patient safety; and

4. Documentation to support the application for waiver.

(d) The Department reserves the right to request additional information before processing a request for waiver.

8:43H-2.9 Action/hearing on a license

All procedures for the imposition of penalties and other enforcement actions/remedies as well as the rights and procedures available to facilities to request a hearing to contest survey findings or the imposition of penalties shall be in accordance with N.J.A.C. 8:43E-3 and 4.

8:43H-2.10 Advertisement of comprehensive rehabilitation hospital/unit

Only facilities licensed as comprehensive rehabilitation hospitals or units may describe and offer themselves to the public as providing comprehensive rehabilitation services. Violation of this requirement will constitute operation of a health care facility without a license, and shall be subject to penalty in accordance with N.J.S.A. 26:2H-14.

SUBCHAPTER 3. GENERAL REQUIREMENTS

8:43H-3.1 Services provided

(a) The facility shall provide preventive, diagnostic, therapeutic, and rehabilitative services to patients in accordance with the rules in this chapter.

(b) The facility shall make available according to the interdisciplinary plan, at a minimum, audiology, dental, dietary, driver evaluation and training, environmental assessment, laboratory, medical, nursing, nutritional counseling, occupational therapy, orthotic and prosthetic, pharmaceutical, physiatry, physical therapy, psychological, radiological, therapeutic recreation, respiratory therapy, social work, speech-language pathology, and vocational services on an inpatient and outpatient basis.

(c) If a health care facility licensed by the Department provides comprehensive rehabilitation services in addition to other health care services, the facility shall adhere to the rules in this chapter and to the rules for licensure of facilities providing the other health care services.

(d) The facility shall adhere to applicable Federal, State, and local laws, rules, regulations, and requirements.

8:43H-3.2 Ownership

(a) The rehabilitation hospital shall disclose the ownership of the rehabilitation hospital and the property on which it is located to the Department. Proof of this ownership shall be available in the facility. Any proposed change in ownership shall be reported to the Director of the Certificate of Need and Acute Care Licensure Program of the Department in writing at least 30 days prior to the change and in conformance with the requirements for Certificate of Need applications at N.J.A.C. 8:33-3.3.

(b) No health care facility shall be owned or operated by any person convicted of a crime relating adversely to the person's capability of owning or operating the facility.

8:43H-3.3 Submission of documents

The rehabilitation hospital shall, upon request, submit any documents which are required by this chapter to the Certificate of Need and Acute Care Licensure Program of the Department.

8:43H-3.4 Personnel

(a) The facility shall develop written job descriptions and ensure that personnel are assigned duties based upon their education, training, and competencies, and in accordance with their job descriptions.

(b) All personnel who require licensure, certification, or authorization to provide patient care shall be licensed, certified, or authorized under the appropriate laws or rules of the State of New Jersey.

(c) The facility shall maintain written staffing schedules. Provision shall be made for substitute staff with equivalent qualifications to replace absent staff members. Staffing schedules shall be implemented to ensure continuity of care and the provision of services consistent with the rehabilitation goals specified in the patient treatment plan.

(d) The facility shall develop and implement a staff orientation and a staff education plan, and designate person(s) responsible for training.

1. All personnel shall receive orientation at the time of employment and continuing in-service education regarding emergency plans and procedures, and the infection prevention and control services.

2. At least one education training program each year shall be held for all administrative and patient care staff regarding the rights and responsibilities of staff under the New Jersey Advance Directives for Health Care Act, N.J.S.A. 26:2H-53 et seq. (P.L. 1991, c.201), and the Federal Patient Self Determination Act (P.L. 101-508), and internal facility policies and procedures to implement these laws.

(e) At least one person trained in cardiopulmonary resuscitation in an approved certification course, as defined in the facility's policy and procedure manual, shall be in all patient areas when patients are present.

8:43H-3.5 Policy and procedure manual

(a) A policy and procedure manual(s) for the organization and operation of the facility shall be developed, implemented, and reviewed at intervals specified in the manual(s). Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility to representatives of the Department at all times. The manual(s) shall include at least the following:

1. A written statement of the program's philosophy and objectives, and the services provided by the facility;

2. An organizational chart delineating the lines of authority, responsibility, and accountability for the administration and patient care services of the facility.

3. A description of the quality improvement program for patient care and staff performance;

4. Specification of business hours and visiting hours;

5. Policies and procedures for reporting all diagnosed and/or suspected cases of child abuse and/or neglect in compliance with N.J.S.A. 9:6-1 et seq., including, but not limited to, the following:

i. The designation of a staff member(s) to be responsible for coordinating the report of diagnosed and/or suspected cases of child abuse and/or neglect, recording the notification to the Division of Youth and Family Services on the medical record, and serving as a liaison between the facility and the Division of the Youth and Family Services;

ii. The development of written protocols for the identification and treatment of abused and/or neglected children; and

iii. The provision of education and/or training programs to appropriate persons regarding the identification and reporting of diagnosed and/or suspected cases of child abuse and/or neglect and regarding the facility's policies and procedures on at least an annual basis;

6. Policies and procedures for the maintenance of confidential personnel records for each employee, including, at a minimum, the employee's name, previous employment, educational background, credentials, license number with effective date and date of expiration (if applicable), certification (if applicable), verification of credentials, records of physical examinations, job description, and evaluations of job performance; and

7. Policies and procedures, including content and frequency, for physical examinations upon employment and subsequently for employees and persons providing direct patient care services through contractual arrangements or written agreements. Such policies and procedures shall ensure that:

i. All personnel, both directly employed and under contract to provide direct care to patients, as well as volunteers, shall receive a Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions are personnel with documented negative Mantoux skin test results (zero to nine millimeters of induration) within the last year, personnel with documented positive Mantoux skin test results (10 or more millimeters of induration), personnel who received appropriate medical treatment for tuberculosis, or when medically contraindicated.

(1) Results of the Mantoux tuberculin skin tests shall be acted upon as follows:

(A) If the Mantoux tuberculin skin test result is between zero and nine millimeters of induration, the test shall be repeated one to three weeks later.

(B) If the Mantoux test result is 10 millimeters or more of induration, a chest x-ray shall be performed and, if necessary, followed by chemoprophylaxis or therapy.

(2) The Mantoux tuberculin skin test shall be administered to all agency personnel, both directly employed and under contract, and thereafter to all new personnel at the time of employment, as well as volunteers. The tuberculin skin test shall be repeated on an annual basis for all persons who provide direct patient care and every two years for all other employees. All employees shall be tested no later than September 30, 2001.

(3) The rehabilitation hospital shall report annually on forms provided by the Department the results of tuberculin testing for all agency personnel and volunteers.

8. All personnel, both directly employed and under contract to provide direct care to patients, shall be given a rubella screening test using the rubella hemagglutination inhibition test or other rubella screening test. The only exceptions are personnel who can document seropositivity from a previous rubella screening test or who can document inoculation with rubella vaccine, or when medically contraindicated.

i. The rehabilitation hospital shall inform each person in writing of the results of his or her rubella screening test.

ii. The rehabilitation hospital shall maintain a list identifying the name of each person who is seronegative and unvaccinated to rubella.

iii. The rehabilitation hospital shall offer rubella vaccination to all employees, contract personnel and volunteers.

iv. A person serving as a volunteer providing direct care to patients shall not be subject to any type of rubella screening test.

9. All personnel, both directly employed and under contract to provide direct care to patients, who were born in 1957 or later shall be given a rubeola (measles) screening test using the hemagglutination inhibition test or other rubeola screening test. The only exceptions are personnel who can document receipt of live measles vaccine on or after their first birthday, physician- diagnosed measles, or serologic evidence of immunity.

i. The rehabilitation hospital shall ensure that all personnel, both directly employed and under contract to provide direct care to patients, who cannot provide serologic evidence of immunity are offered rubella and rubeola vaccination.

ii. A person serving as a volunteer providing direct care to patients shall not be subject to any type of rubeola screening test.

10. The rehabilitation hospital shall have available and shall comply with the guidelines listed below, incorporated herein by reference, to protect health care workers who may be exposed to infectious blood-borne diseases, such as AIDS and hepatitis-B:

i. "Enforcement Procedures for Occupational Exposure to Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV)," OSHA Instruction CPL-2-2.44B, August 15, 1990, as amended and supplemented;

ii. "Recommendations for Prevention of HIV Transmission in Health Care Settings," CDC, Morbidity and Mortality Weekly Report (MMWR) 1987; Volume 36 (supplement 2S), as amended and supplemented; and

iii. "Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens in Health Care Settings," CDC Morbidity and Mortality Weekly Report (MMWR) 1988; Volume 37, as amended and supplemented.

(b) The policy and procedure manual(s) shall be available and accessible to all patients, staff, and the public.

8:43H-3.6 Patient transportation

The facility shall develop and implement methods of patient transportation for services provided outside the facility, including emergency services, which includes plans for security and accountability for the patient and his or her personal possessions.

8:43H-3.7 Written agreements

(a) The rehabilitation hospital shall have a written agreement, or its equivalent, for services provided by contract or subcontract. The written agreement, or its equivalent, shall:

1. Be dated and signed by a representative of the rehabilitation hospital and by the person or agency providing the service;

2. Specify each party's responsibilities, functions, and objectives, the time during which services are to be provided, the financial arrangements and charges, and the duration of the written agreement or its equivalent;

3. Specify that the rehabilitation hospital shall retain administrative responsibility for services rendered, including subcontracted services;

4. Require that services are provided in accordance with this chapter and that personnel providing services meet training and experience requirements and are supervised in accordance with this chapter; and

5. Require that written documentation of services be provided to the facility within seven working days of execution of the contract, including, but not limited to, documentation of services rendered by the person or agency providing the service.

8:43H-3.8 Reportable events

(a) The facility shall notify the Department immediately by telephone at 609- 292-9900 (1-800-792-9770 after business hours), of any event occurring within the facility that jeopardizes the health and safety of patients or employees. Events which shall be reported to the Department include, but are not limited to, the following:

1. An unscheduled interruption for three or more hours of physical plant and/or clinical services essential to the health and safety of patients and employees;

2. All fires, disasters, or accidents which result in serious injury or death of patients or employees, or in evacuation of patients out of the facility;

3. All alleged or suspected crimes which endanger the life or safety of patients or employees, which are also reportable to the police department, and which result in an immediate on-site investigation by the police;

4. Any other unexpected patient and employee death or serious injury; and

5. The presence of epidemic disease in the facility.

(b) Information received by the Department of Health and Senior Services through immediate notification shall not be disclosed to public in such a way as to indicate the names of the specific patients or hospital employees to whom the information pertains.

(c) A follow-up written report shall be submitted to the Department within seven calendar days of the event, unless determined not to be necessary by the Department. The written report shall contain information about injuries to patients and/or staff, disruption of services, extent of damages and corrective actions taken.

8:43H-3.9 Notices

(a) The rehabilitation hospital shall conspicuously post a notice that the following information is available in the facility during the facility's regular business hours to patients and the public:

1. All waivers granted by the Department;

2. All documents required by this chapter;

3. A list of deficiencies from the last annual licensure inspection and certification survey report (if applicable), and the list of deficiencies from any valid complaint investigation during the past 12 months;

4. A list of the rehabilitation hospital committees, or their equivalents, and the membership of each; and

5. Policies and procedures regarding patient rights;

(b) A rehabilitation hospital shall maintain on file in the administrator's office, the following information for any interested party to review:

1. The names and addresses of members of the governing authority; and

2. Any changes or membership of the governing authority, within 30 days after the change.

8:43H-3.10 Reporting information to State Board of Medical Examiners

(a) A rehabilitation hospital shall make reports to the Medical Practitioner Review Panel for all events specified at N.J.S.A. 26:2H-12.2 with respect to any practitioner employed by, or under contract to, the rehabilitation hospital.

(b) For purpose(s) of (a) above, "practitioner" means physician, medical resident or intern, or podiatrist.

(c) The rehabilitation hospital shall provide the required notification within seven days of the date of the action, settlement, judgement or award to the New Jersey State Board of Medical Examiners, 140 East Front Street, Trenton, New Jersey 08608. (Questions may be directed to the Board office at (609) 292- 4843).

8:43H-3.11 Reporting to professional licensing boards

The rehabilitation hospital shall comply with all requirements of the professional licensing boards for reporting termination, suspension, revocation, or reduction of privileges of any health professional licensed in the State of New Jersey.

8:43H-3.12 Financial reports

(a) Upon development of a uniform cost reporting system approved by the Health Care Administration Board, the facility shall adopt and maintain the uniform system of cost reporting from which reports will be prepared to meet the requirements of the Commissioner as stated in N.J.S.A. 26:2H-1 et seq., and amendments thereto.

(b) An annual financial report shall be submitted to the Department and shall include a statement of income and expenditure.

SUBCHAPTER 4. GOVERNING AUTHORITY

8:43H-4.1 Responsibility of the governing authority

(a) The facility shall have a governing authority which shall assume legal responsibility for the management, operation, and financial viability of the facility. The governing authority shall be responsible for, but not limited to, the following:

1. Services provided and the quality of care rendered to patients;

2. Provision of a safe physical plant equipped and staffed to maintain the facility and services;

3. Adoption and documented review of written bylaws, or their equivalent, according to a schedule established by the governing authority;

4. Appointment, reappointment, assignment of privileges, and curtailment of privileges of health care professionals, and written confirmation of such actions;

5. Development and documented review of all policies and procedures, according to a schedule established by the governing authority;

6. Establishment and implementation of a system whereby patient and staff grievances and/or recommendations, including those relating to patient rights, can be identified within the facility. This system shall include a feedback mechanism through management to the governing authority, indicating what action was taken;

7. Determination of the frequency of meetings of the governing authority and its committees, or their equivalents, conducting such meetings, and documenting them through minutes;

8. Delineation of the duties of the officers of any committees, or their equivalent, of the governing authority. When the governing authority establishes committees or their equivalents, their purpose, structure, responsibilities, and authority, and the relationship of the committee or its equivalent to other entities within the facility shall be documented;

9. Establishment of the qualifications of members and officers of the governing authority, the procedures for electing and appointing officers, and the terms of service for members, officers, and committee chairpersons or their equivalents; and

10. Approval of the medical staff bylaws or their equivalent.

SUBCHAPTER 5. ADMINISTRATION

8:43H-5.1 Appointment of administrator

The governing authority shall appoint an operations manager accountable for rehabilitation services who shall be available to the facility at all times. An alternate shall be designated in writing to act in the absence of the operations manager accountable for rehabilitation services.

8:43H-5.2 Administrator's responsibilities

(a) The administrator shall be responsible for, but not limited to, the following:

1. Ensuring the development, implementation, and enforcement of all policies and procedures, including patient rights;

2. Planning for, and the administration of, the managerial, operational, fiscal, and reporting components of the facility;

3. Participating in the quality improvement program for patient care and staff performance;

4. Ensuring that all personnel are assigned duties based upon their education, training, competencies, and job descriptions;

5. Ensuring the provision of staff orientation and staff education; and

6. Establishing and maintaining liaison relationships, communication, and integration with facility staff and services and with patients and their families.

8:43H-5.3 Advance directives; dispute resolution; forum for discussion; community education

(a) The facility shall establish procedures for considering disputes among the patient, the health care representative and the attending physician concerning the patient's decision-making capacity or the appropriate interpretation and application of the terms of an advance directive to the patient's course of treatment. The procedures may include consultation with an institutional ethics committee, a regional ethics committee or another type of affiliated ethics committee, or with any individual or individuals who are qualified by their background and/or experience to make clinical and ethical judgments.

(b) The facility shall establish a process for patients, families and staff to discuss and address questions and concerns relating to advance directives and decisions to accept or reject medical treatment.

(c) The facility shall provide periodic community education programs, individually or in coordination with other area facilities or organizations, that provide information to consumers regarding advance directives and their rights under New Jersey law to execute advance directives.

8:43H-5.4 Policies and procedures for advance directives

(a) For purposes of this chapter, "advance directive" means a written statement of a patient's instructions and directions for health care in the event of future decision making incapacity, in accordance with the New Jersey Advance Directives for Health Care Act, N.J.S.A. 26:2H-53 et seq., (P.L. 1991, c.201) and any rules which may be promulgated pursuant thereto. An advance directive may include a proxy directive, and instruction directive, or both.

(b) The facility shall develop and implement procedures to ensure that there is a routine inquiry made of each adult patient, upon admission to the facility and at other appropriate times, concerning the existence and location of an advance directive. If the patient is incapable of responding to this inquiry, the facility shall have procedures to request the information from the patient's family or, in the absence of a family member, another individual with personal knowledge of the patient. The procedures must assure that the patient or family's response to this inquiry is documented in the medical record. Such procedures shall also define the role of facility admissions, nursing, social service and other staff as well as the responsibilities of the attending physician.

(c) The facility shall develop and implement procedures to promptly request and take reasonable steps to obtain a copy of currently executed advance directives from all patients. These shall be entered when received into the medical record of the patient.

(d) A patient shall be transferred to another health care facility only for a valid medical reason, in order to comply with other applicable laws or Department rules, to comply with clearly expressed and documented patient choice, or in conformance with the New Jersey Advance Directives for Health Care Act in the instance of private, religiously affiliated health care institutions who establish policies defining circumstances in which it will decline to participate in the implementation of advance directives. Such institutions shall provide notice to patients or their families or health care representatives prior to or upon admission of their policies. A timely and respectful transfer of the individual to another institution which will implement the patient's advance directive shall be effected. The facility's inability to care for the patient shall be considered a valid medical reason. The sending facility shall receive approval from a physician and the receiving health care facility before transferring the patient.

(e) The facility shall, in consultation with the attending physician, take all reasonable steps to effect the appropriate, respectful and timely transfer of patients with advance directives to the care of an alternative health care professional in those instances where a health care professional declines as a matter of professional conscience to participate in withholding or withdrawing life-sustaining treatment. In those instances where the health care professional is the patient's physician, the facility shall take reasonable steps, in cooperation with the physician, to effect the transfer of the patient to another physician's care in a responsible and timely manner. Such transfer shall assure that the patient's advance directive is implemented in accordance with their wishes within the facility, except in cases governed by (d) above.

(f) The facility shall have procedures to provide each adult patient upon admission and, where the patient is unable to respond, to the family or other representative of the patient, with a written statement of their rights under New Jersey law to make decisions concerning the right to refuse medical care and the right to formulate an advance directive. Such statement shall be issued by the Commissioner. Appropriate written information and materials on advance directives and the institution's written policies and procedures concerning implementation of such rights shall also be provided. Such written information shall also be made available in any language which is spoken, as a primary language, by more than 10 percent of the population served by the facility.

(g) The facility shall develop and implement procedures for referral of patients requesting assistance in executing an advance directive or additional information to either staff or community resource persons that can promptly advise and/or assist the patient.

(h) The facility shall develop and implement policies to address application of the facility's procedures for advance directives to patients who experience an urgent life-threatening situation.

(i) The facility shall develop and implement policies and procedures for the declaration of death of patients, in instances where applicable, in accordance with N.J.S.A. 26:6 and the New Jersey Declaration of Death Act, N.J.S.A. 26:6A-1 et seq. (P.L. 1991, c.90). Such policies shall also be in conformance with rules promulgated by the New Jersey Board of Medical Examiners which address declaration of death based on neurological criteria, including the qualifications of physicians authorized to declare death based on neurological criteria and the acceptable medical criteria, tests, and procedures which may be used. The policies and procedures must also accommodate a patient's religious beliefs with respect to declaration of death.

8:43H-5.5 Policies and procedures for admission of a pediatric patient at least 16 years of age to an adult rehabilitation hospital

(a) In order to admit a patient at least 16 years of age to an adult rehabilitation hospital, the following process shall be followed:

1. If the adult rehabilitation hospital receives a referral of a patient at least 16 years of age, the adult rehabilitation hospital shall advise the referral source that the patient must first be referred to a pediatric rehabilitation hospital. The adult rehabilitation hospital shall also contact

the pediatric rehabilitation hospital in the geographic location closest to the patient to advise them that such a referral is also being made for adult rehabilitation services.

2. For the adult rehabilitation hospital to proceed with admitting the patient, it must receive, within 48 hours of the referral, a recommendation from the pediatric rehabilitation hospital, based on its review of clinical and psychosocial information related to the patient, regarding the patient's admission to the adult rehabilitation hospital.

3. The adult rehabilitation hospital must also receive a written recommendation regarding the patient's admission from the case manager/discharge planner at the acute care hospital and from the patient's attending physician.

4. If this process has been carried out and does not result in a favorable recommendation(s) for admission to the adult rehabilitation facility, the patient has the right to be admitted to the adult facility notwithstanding.

5. Adult rehabilitation hospitals shall not admit patients who have not had their 16th birthday.

8:43H-5.6 Policies and procedures for admission of a adult patient to a pediatric rehabilitation hospital

(a) In order to admit a patient 20 years of age or older to a pediatric rehabilitation hospital, the following process shall be followed:

1. If the pediatric rehabilitation hospital receives a referral of a patient 20 years of age or older, the pediatric rehabilitation hospital shall advise the referral source that the patient must first be referred to an adult rehabilitation hospital. The pediatric rehabilitation hospital shall also contact the adult rehabilitation hospital in the geographic location closest to the patient to advise them that such a referral is also being made for pediatric rehabilitation services.

2. For the pediatric rehabilitation hospital to proceed with admitting the patient, it must receive, within 48 hours of the referral, a recommendation from the adult rehabilitation hospital, based on its review of clinical and psychosocial information related to the patient, regarding the patient's admission to the pediatric rehabilitation hospital.

3. The pediatric rehabilitation hospital must also receive a written recommendation regarding the patient's admission from the case manager/discharge planner at the acute care hospital and from the patient's attending physician.

4. If this process has been carried out and does not result in a favorable recommendation(s) for admission to the pediatric rehabilitation facility, the patient has the right to be admitted to the pediatric facility notwithstanding.

SUBCHAPTER 6. PATIENT CARE POLICIES

8:43H-6.1 Policies and procedures

(a) Written patient care policies and procedures shall be established, implemented, and reviewed at intervals specified in the policies and procedures. Each review of the policies and procedures shall be documented. Policies and procedures shall include, but not be limited to, policies and procedures for the following:

1. Patient rights;

2. The determination of staffing levels on the basis of patient acuity;

3. The referral of patients to other health care providers and medical consultative services. Medical consultative services shall include, at a minimum, the following: cardiology, dental, surgery, internal medicine, neurology, neurosurgery, ophthalmology, orthopedic surgery, otorhinolaryngology, pediatrics, plastic surgery, podiatry, psychiatry, pulmonary medicine, and urology;

4. The provision of sexual counseling services directly in the facility, in accordance with the patient treatment plan;

5. The provision of consultation for environmental modification services in the patient's living environment, in accordance with the care plan;

6. Emergency care of patients, in accordance with this chapter;

7. Obtaining written informed consent;

8. Patient instruction and health education, including the provision of printed and/or written instructions and information for patients, with multilingual instructions as indicated;

9. Admission of patients;

10. Orientation for the patient and his or her family, conducted by the facility's designated representative, prior to or at the time of the patient's admission. The orientation shall include, at a minimum, the following: facility policies, business hours, fees for services known at the time of admission, services provided, patient rights, and criteria for admission, treatment, and discharge. Documentation of orientation shall be in the patient's medical record;

11. Restrictions to the admission and retention of patients, to ensure that:

i. A patient who manifests such a degree of behavioral disorder that he or she is a danger to himself or herself or others, or whose behavior interferes with the health or safety of other patients, shall not be admitted or retained; and

ii. A patient suffering from substance abuse or misuse only shall not be admitted to or retained in the facility;

12. Telephone orders, to ensure that they are written into the patient's medical record by the person accepting them, and countersigned by the prescriber within the time frame prescribed by N.J.A.C. 8:43G-16.2(a)4 and (b). Verbal orders shall be limited to emergency situations, as defined in the facility's policies and procedures;

13. Financial arrangements, to ensure that the facility:

i. Informs patients of the fees for services;

ii. Maintains a written record of all financial arrangements with the patient and/or his or her family, with copies furnished to the patient upon request;

iii. Assesses no additional charges, expenses, or other financial liabilities in excess of the facility's rate, except:

(1) Upon written approval and authority of the patient and/or his or her family, who shall be given a copy of the written approval; or

(2) In the event of a health emergency involving the patient and requiring immediate, special services or supplies to be furnished during the period of the emergency;

iv. Consults with patients regarding insurance coverage and referral systems for patients' financial assistance; and

v. Describes sliding fee scales and any special payment plans established by the facility;

14. Interpretation and communication services as appropriate to meet patient needs;

15. The control of smoking in the facility in accordance with N.J.S.A. 26:3D-1 et seq. and 26:3D-7 et seq.;

16. Except in the case of a competent adult, notification of the patient's family in the event that the patient sustains an injury, immediately after the occurrence. In the event of an accident or incident that does not result in injury to the patient, notification of the patient's family is to occur within 24 hours of the occurrence. Immediately following such notification, the notification shall be documented in the patient's medical record;

17. The use of restraints, including at least the following:

i. Specification of the uses of restraints and types of restraints permitted, as well as of the use of alternatives to restraints such as staff or environmental interventions, structured activities, or behavior management. Alternatives shall be utilized whenever possible to avoid the use of restraints. The specific nature of the device used to restrain the patient does not in itself determine whether it is a restraint. Rather, it is the device's intended use, its involuntary application, and/or the identified patient need that determines whether the device is a physical restraint. Therefore, this policy of requiring alternatives to restraints does not apply to:

(1) Standard practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures and the related post-procedure care processes;

(2) Adaptive support in response to assessed patient need (for example, postural support, orthopedic appliances, tabletop chairs, bedrails);

(3) Helmets; and

(4) Therapeutic holding or comforting of patients.

ii. Prohibition of the use of locked restraints and confinement of a patient in a locked or barricaded room, and prohibition of the use of restraints for punishment or for the convenience of facility personnel;

iii. A delineation of indications for use, which should be limited to:

(1) Prevention of imminent harm to the resident or other persons when other means of control are not effective or appropriate; or

(2) Prevention of serious disruption of treatment or significant damage to the physical environment.

iv. Written protocols for:

(1) Informing the patient and obtaining consent when clinically feasible, and documenting the consent in the patient's record;

(2) Notifying the family or guardian, obtaining consent if the patient is unable to give consent and documenting the consent in the patient's record; and

(3) Removing restraints when goals have been accomplished; and

v. A requirement that a physical restraint shall only be used when authorized in writing by a physician except when necessitated by an emergency, in which case it shall be approved by the medical director, or the nurse accountable for the rehabilitation nursing service or his or her designee;

18. Discharge, transfer and readmission of patients, including criteria for each:

i. Written notification by the administrator shall be provided to a patient of a decision to involuntarily discharge him or her from the facility. The notice shall include the reason for discharge and the patient's right to appeal. A copy of the notice shall be entered in the patient's medical record;

ii. The patient shall have the right to appeal to the administrator any involuntary discharge from the facility. The appeal shall be in writing and a copy shall be included in the patient's medical record with the disposition or resolution of the appeal;

19. The care and control of assistive animals (that is, seeing-eye dogs, service dogs), as well as the care and control of pets if the facility permits pets in the facility or on its premises;

20. The calibration of instruments of measurement, including the frequency of calibration; and

21. Care of deceased patients, including, but not limited to, the following:

i. Pronouncement of death. The patient's family shall be notified at the time of death. The deceased shall not be discharged from the facility until pronounced dead and the death documented in the patient's medical record;

ii. Removal of the deceased from rooms occupied by other patients; and

iii. Transportation of the deceased in the facility, and removal from the facility, in a dignified manner.

SUBCHAPTER 7. PATIENT ASSESSMENTS; INTERDISCIPLINARY CARE PLANS

8:43H-7.1 Patient interdisciplinary care plans

(a) Each patient shall have a written interdisciplinary care plan, developed under the direction of a physician, which is based upon assessments of his or her needs by the interdisciplinary team.

1. The physician responsible for providing care to the patient shall document in the patient's medical record an admission and medical history and a report of physical examination within 24 hours of admission, the plan of care, and progress notes and shall participate as part of the interdisciplinary team in developing, implementing, reviewing, and revising the interdisciplinary care plan.

2. A written interdisciplinary care plan shall be developed by the health care practitioners participating in the patient's care. The interdisciplinary care plan shall be initiated upon the patient's admission and include, but not be limited to: care to be provided based upon the patient assessments, an evaluation of the patient's potential for improving his or her functional level, goals consistent with the patient's potential for rehabilitation, and the patient's discharge plan. If the patient does not need a service, a care plan is not needed for that service.

3. The patient treatment plan shall be developed from the assessments by the multidisciplinary team and initiated upon the patient's admission. The patient treatment plan shall include, but not be limited to, the following:

i. Orders for treatment or services, medications, and diet;

ii. The patient's rehabilitation goals for himself or herself;

iii. The specific rehabilitation goals of treatment or services;

iv. The time intervals, which shall not exceed 14 days, at which the patient's response to treatment or services will be reviewed;

v. Anticipated time frame(s) for the accomplishment of the rehabilitation goals;

vi. The measures to be used by the interdisciplinary team to assess the effects of treatment or services shall include:

(1) An evaluation of the patient's potential for improving his or her functional level;

(2) Specific rehabilitation goals and timeframes consistent with the patient's potential for rehabilitation;

(3) Orders for treatment of services, medications and diet;

(4) The time intervals (not to exceed 14 days) at which the patient's response to treatment or services will be reviewed;

(5) The measures to be used to assess the effects of treatment or services; and

(6) The patient's discharge plan.

(b) The patient and, if appropriate, family members shall participate in the development of the interdisciplinary care plan including the discharge plan. Participation shall be documented in the patient's medical record.

1. If, in the opinion of a physician, the patient's participation in the development of the interdisciplinary care plan is medically contraindicated, as documented in the patient's medical record, a designated member of the interdisciplinary team shall review the interdisciplinary care plan with the patient prior to implementation, and, if appropriate, the family shall be informed of the interdisciplinary care plan.

8:43H-7.2 Implementation of plans

(a) Each health care practitioner participating in the patient's care shall provide services in accordance with the interdisciplinary care plan.

(b) Each health care practitioner providing services to the patient shall establish criteria to measure the effectiveness and outcome of services provided and shall assess and reassess the patient to determine if services provided meet the established criteria. Assessment and reassessment shall be documented in the patient medical record.

(c) Each discipline providing services to the patient shall participate as a member of the interdisciplinary team in developing, implementing, reviewing and revising the interdisciplinary care plan.

1. The interdisciplinary team shall review and revise the interdisciplinary care plan based upon the patient's response to the care provided by each of the participating services. Documentation in the patient's medical record shall indicate review and revision of the interdisciplinary care plan.

SUBCHAPTER 8. MEDICAL SERVICES

8:43H-8.1 Provision of medical services

Medical services shall be provided to all patients 24 hours a day, seven days a week, directly in the facility.

8:43H-8.2 Appointment of medical director

A medical director shall be appointed. The medical director shall provide services in accordance with facility by-laws and policies. Comprehensive rehabilitation services shall be provided under the direction of the medical director. The medical director shall designate in writing a physician to act in his or her absence.

8:43H-8.3 Medical director's responsibilities

(a) The medical director shall be responsible for the direction, provision, and quality of medical services provided to patients. He or she shall be responsible for, but not limited to, the following:

1. Developing and maintaining written objectives, policies, a procedure manual, an organizational plan, and a quality improvement program for the medical service;

2. Participating in planning and budgeting for the medical service;

3. Coordinating and integrating the medical service with other patient care services to provide a continuum of care for the patient;

4. Assisting in developing and maintaining written responsibilities for the medical staff, and assigning duties based upon education, training, competencies; and

5. Developing, implementing, and reviewing written medical policies in accordance with medical staff bylaws or their equivalent, in cooperation with the medical staff, including, but not limited to, the following:

i. A plan for medical staff meetings and their documentation through minutes;

ii. A mechanism for establishing and implementing procedures relating to credentials review, delineation of qualifications, medical staff appointments and reappointments, evaluation of medical care, and the granting, denial, curtailment, suspension, or revocation of medical staff privileges; and

iii. A system for completion of entries in the patient medical record by members of the medical staff. Entries shall be signed by a physician in accordance with the facility's policies and procedures.

8:43H-8.4 Responsibilities of physicians

The physician primarily responsible for providing care to the patient shall document in the patient's medical record an admission medical history, and a report of physical examination and medical decision making within 24 hours of admission and progress notes and shall directly participate as part of the interdisciplinary team in developing, implementing, reviewing, and revising the interdisciplinary care plan.

8:43H-8.5 Availability of pediatrician

If the facility provides care for pediatric patients, a pediatrician shall be available.

8:43H-8.6 Availability of physiatrist

If the medical director of a facility providing services to pediatric patients is a pediatrician, a physiatrist shall be available, in accordance with medical bylaws and facility policy and procedures.

SUBCHAPTER 9. NURSING SERVICES

8:43H-9.1 Provision of nursing services

(a) The facility shall provide nursing services to patients 24 hours a day, seven days a week, directly in the facility.

(b) At least one registered professional nurse and one licensed nurse, excluding the director of nursing services or his or her designee, shall be assigned to each nursing unit 24 hours a day, seven days a week. Additional licensed nursing personnel and ancillary nursing personnel shall be provided in accordance with the facility's patient care policies and procedures for determining staffing levels on the basis of acuity of patient need.

(c) A registered professional nurse who has completed a baccalaureate degree program accredited by the National League for Nursing and who is eligible to be certified by the Association of Rehabilitation Nurses shall develop, supervise and assess the staff orientation and staff education provided to nursing personnel.

(d) The hospital, under the direction of the nursing service, shall utilize the approved State Board of Nursing Unlicensed Assistive Personnel (UAP) curriculum in the development and implementation of a training program for unlicensed assistive personnel. There shall be methods for evaluating minimal competencies and a requirement for annual in-service education. A copy of the State Board of Nursing UAP curriculum may be obtained by sending a request to the following address:

Executive Director
State Board of Nursing
PO Box 45009
Newark, New Jersey 07101

8:43H-9.2 Appointment of registered professional nurse accountable for the rehabilitation nursing service

A registered professional nurse shall be appointed in writing to be accountable for the rehabilitation nursing service and shall be on duty at all times. A registered professional nurse shall be designated in writing to act in his or her absence.

8:43H-9.3 Responsibilities of registered professional nurse accountable for the rehabilitation nursing service

(a) The registered professional nurse to be accountable for the rehabilitation nursing service shall be responsible for the direction, provision, and quality of nursing service provided to patients. He or she shall be responsible for, but not limited to, the following:

1. Developing and implementing written objectives, philosophy, policies, a procedure manual, an organizational plan, and participating in the facility's quality improvement program;

2. Participating in planning and budgeting for the nursing service;

3. Coordinating and integrating the nursing service with other patient care services to provide a continuum of care for the patient;

4. Assisting in developing and maintaining written job descriptions for nursing and ancillary nursing personnel, and assigning job duties based upon education, training, continued competencies, and job descriptions;

5. Ensuring that nursing services are provided to the patient as specified in the interdisciplinary care plan, which shall be initiated upon the patient's admission, and that nursing personnel are assigned to patients in accordance with the facility's patient care policies and procedures for determining staffing levels on the basis of acuity of patient need; and

6. Providing for a planned orientation program in rehabilitation nursing concepts.

8:43H-9.4 Responsibilities of licensed nursing personnel

(a) In accordance with the State of New Jersey Nursing Practice Act, N.J.S.A. 45:11-23 et seq., as interpreted by the New Jersey State Board of Nursing, and written job descriptions, licensed nursing personnel shall be responsible for providing nursing care, including, but not limited to, the following:

1. Care of patients through health promotion, maintenance, and restoration;

2. Care toward prevention of infection, accident, and injury;

3. Assessing the nursing care needs of the patient, preparing the interdisciplinary care plan based upon the assessment, providing nursing care services as specified in the interdisciplinary care plan, reassessing the patient's response to services provided, and revising the interdisciplinary care plan. Each of these activities shall be documented in the patient's medical record. A registered professional nurse shall assess each patient to identify the patient's needs and problems and develop a care plan;

4. Teaching, supervising, and counseling the patient, family and staff regarding nursing care and the patient's needs. Only a registered professional nurse shall initiate these functions, which may be reinforced by licensed nursing personnel;

5. Participating as part of the interdisciplinary team in developing, implementing, reviewing, and revising the interdisciplinary care plan;

6. Writing clinical notes and progress notes; and

7. Assisting the patient in activities of daily living based upon the patient's strengths, needs, abilities, and preferences.

8:43H-9.5 Nursing care services related to pharmaceutical services

(a) Nursing personnel shall be responsible for, but not limited to, ensuring the following:

1. All drugs administered are prescribed in writing and the order signed and dated by the prescriber. Drugs shall be administered in accordance with all Federal and State laws and rules by the following licensed or authorized nursing personnel:

i. Registered professional nurses;

ii. Licensed practical nurses who are trained in drug administration in programs approved by the New Jersey State Board of Nursing;

iii. Nurses with a valid temporary work permit issued by the New Jersey State Board of Nursing; and

iv. Student nurses in a school of nursing approved by the New Jersey State Board of Nursing, under the supervision of a nurse faculty member;

2. Drugs are not prepoured. Drugs shall be administered promptly after the dose has been prepared, and by the individual who prepared the dose, except when a unit dose drug distribution system is used;

3. The patient is identified prior to drug administration. Drugs prescribed for one patient shall not be administered to another patient;

4. A record of drugs administered is maintained. After each drug administration, the following shall be documented by the nurse who administered the drug: name and strength of the drug, date and time of administration, dosage administered, method of administration, and signature of the nurse who administered the drug;

5. All drugs are kept in locked storage areas, except intravenous infusion solutions which shall be stored according to a system of accountability, as specified in the facility's

policies and procedures. Drug storage and preparation areas shall be kept locked when not in use. Drugs requiring refrigeration shall be kept in a separate, locked box in the refrigerator, in a locked refrigerator, or in a refrigerator in the locked medication room. The refrigerator shall have a thermometer to indicate temperature in conformance with U.S.P. (United States Pharmacopoeia) requirements;

6. Needles and syringes are procured, stored, used, and disposed of in accordance with the laws of the State of New Jersey and amendments thereto. There shall be a system of accountability for the disposal of used needles and syringes which shall not necessitate the counting of individual needles and syringes after they are placed in the container for disposal; and

7. Drugs are stored and verified according to the following:

i. Drugs in Schedules III and IV of the Controlled Dangerous Substances Acts and amendments thereto shall be stored under lock and key. Drugs in Schedule II of the Controlled Dangerous Substances Acts and amendments thereto shall be stored in a separate, locked, permanently affixed compartment within the locked medication cabinet, medication room, refrigerator, or mobile medication cart. The key to the separate, locked compartment for Schedule II drugs shall not be the same key that is used to gain access to storage areas for other drugs (except that drugs in Schedule II in a unit dose drug distribution system shall be kept under double lock and key, but may be stored with other controlled drugs);

ii. The keys for the storage compartments for drugs in Schedules II, III, and IV shall be kept on a person who meets the criteria listed in (a)1i through iv above; and

iii. Except in a unit dose drug distribution system, a declining inventory of all drugs in Schedule II of the Controlled Dangerous Substances Acts and amendments thereto shall be made at the termination of each tour of duty wherever these drugs are maintained. This record shall be signed by both the outgoing and incoming nurses who shall meet the criteria listed in (a)1i through iv above. The following shall be recorded: name of the patient receiving the drug, prescriber's name, name and strength of the drug, date received from the pharmacy, date of administration, dosage administered, method of administration, signature of the licensed nurse who administered the drug, amount of drug remaining, amount of drug destroyed or wasted (when appropriate), and the signature of the nurse who witnessed the destruction or wasting of the drug (when appropriate).

SUBCHAPTER 10. PHARMACEUTICAL SERVICES

8:43H-10.1 Provision of pharmaceutical services

Pharmaceutical services shall be provided to patients 24 hours a day, seven days a week, directly in the facility. If the facility has an institutional pharmacy, the pharmacy shall be licensed by the New Jersey State Board of Pharmacy and operated in accordance with the New Jersey State Board of Pharmacy Rules, N.J.A.C. 13:39, and shall possess a current Drug Enforcement Administration registration and a Controlled Dangerous Substance registration from the Department in accordance with the Controlled Dangerous Substances Acts.

8:43H-10.2 Appointment of pharmacist

(a) A pharmacist shall be appointed and shall be responsible for the direction, provision, and quality of the pharmaceutical services. The pharmacist shall be responsible for, but not limited to, the following:

1. Together with the Pharmacy and Therapeutics Committee, developing and maintaining written objectives, policies, and a procedure manual, an organizational plan, and a quality assurance program for the pharmaceutical service;

2. Participating in planning and budgeting for the pharmaceutical service;

3. Coordinating and integrating the pharmaceutical service with other patient care services to provide a continuum of care for the patient;

4. Assisting in developing and maintaining written job descriptions for pharmacy personnel, if any, and assigning duties based upon education, training, competencies, and job descriptions;

5. Participating as part of the multidisciplinary team in developing, implementing, reviewing, and revising the patient treatment plan;

6. Maintaining a means of identifying the signatures of all prescribers authorized to use the pharmaceutical service for prescriptions; and

7. Maintaining records of the transactions of the pharmaceutical service, as required by Federal, State, and local laws, to ensure control and accountability of all drugs. This shall include a system of controls and records for the requisitioning and dispensing of pharmaceutical supplies to all services of the facility.

8:43H-10.3 Pharmacy and Therapeutics Committee

(a) A multidisciplinary Pharmacy and Therapeutics Committee shall be appointed by and accountable to the governing authority. The committee shall be responsible for, but not limited to, the following:

1. Development of policies and procedures, approved by the governing authority, and documentation of their review. These policies and procedures shall govern evaluation, selection, obtaining, dispensing, storage, distribution, administration, use, control, accountability, and safe practices pertaining to all drugs used in the treatment of patients;

2. Development and at least annual review and approval of a current formulary ("Formulary" means a list of all drugs approved for use in the facility. It may also list drugs which are considered appropriate for treating specific illnesses, or may list substitutions of chemically or therapeutically equivalent drugs for trade name prescription drugs.); and

3. Approval of the minimal pharmaceutical reference materials to be retained at each nursing unit, those to be kept in the pharmacy and made available to at least nursing personnel and the medical staff, and methods for communicating product information to at least nursing personnel and the medical staff.

8:43H-10.4 Policies and procedures for drug administration

(a) The facility's policies and procedures shall ensure that the right drug is administered to the right patient in the right amount through the right route of administration and at the right time. Policies and procedures shall include, but not be limited to, the following:

1. Policies and procedures for the implementation of a unit dose drug distribution system;

i. The facility shall have a unit dose drug distribution system. ("Unit dose drug distribution system" means a system in which drugs are delivered to patient areas in single unit packaging. Each patient has his or her own receptacle, such as a tray, bin, box, cassette, drawer, or compartment, labeled with his or her first and last name and room number, and containing his or her own medications. Each medication is individually wrapped and labeled with the generic name, trade name (if appropriate), and strength of the drug, lot number or reference code, expiration date, and manufacturer's or distributor's name, and ready for administration to the patient.) At least one exchange of patient medications shall occur every three days. The number of doses for each patient shall be sufficient for a maximum of 72 hours. No more than a 72-hour supply of doses shall be delivered to or available in the patient care area at any time;

ii. Cautionary instructions and additional information, such as special times of administration, regarding dispensed medications shall be transmitted to the personnel responsible for the administration of the medications;

iii. If the facility repackages medications in single unit packages, the facility's policies and procedures shall indicate how such packages shall be labeled to identify the lot number or reference code and manufacturer's or distributor's name; and

iv. Policies and procedures shall specify the drugs which will not be obtained from manufacturers or distributors in single unit packages and will not be repackaged as single units in the facility;

2. Methods for procuring drugs on a routine basis, in emergencies, and in the event of disaster;

3. Policies and procedures, approved by the Pharmacy and Therapeutics Committee in accordance with these rules, regarding emergency kits and emergency carts, including the following:

i. Approval of their locations and contents;

ii. Provision for pediatric doses in areas of the facility where pediatric emergencies may occur;

iii. Determination of the frequency of checking contents, including expiration dates;

iv. Approval of the assignment of responsibility for checking contents; and

v. A requirement that emergency kits are secure but are not kept under lock and key;

4. Policies and procedures, approved by the medical staff of the facility, to ensure that all drugs are ordered in writing, that the written order specifies the name of the drug, dose, frequency, and route of administration, that the order is signed and dated by the prescriber, and that all drugs are administered in accordance with the laws of the State of New Jersey;

5. Policies and procedures for drug administration, including, but not limited to, establishment of the times for administration of drugs prescribed;

6. If facility policy permits, policies and procedures regarding self- administration of drugs. ("Self-administration" means a procedure in which any medication is taken orally, injected, inserted, or topically or otherwise administered by a patient to himself or herself.) Policies and procedures for self-administration shall include, but not be limited to, the following:

i. A requirement that self-administration be permitted only upon a written order of the prescriber;

ii. Storage of drugs;

iii. Labeling of drugs;

iv. Methods for documentation in the patient's medical record of self- administered drugs;

v. Training and education of patients in self-administration and the safe use of drugs; and

vi. Establishment of precautions so that patients do not share their drugs or take the drugs of another patient;

7. Policies and procedures for documenting and reviewing adverse drug reactions and medication errors. Allergies, including allergy to latex, shall be documented in the patient's open medical record and on its outside front cover, as well as in the patient's pharmacy profile.

8. Policies and procedures for ensuring the immediate delivery of stat. doses. Stat. (statim) shall mean immediately;

9. If facility policy permits, policies and procedures for the use of floor stock drugs. "Floor stock" means a supply of drugs provided by the pharmacist to a service or unit in a labeled container in limited quantities, as approved by the Pharmacy and Therapeutics Committee of the facility. A list shall be maintained of floor stock drugs and their amounts stored throughout the facility;

10. Policies and procedures for discontinuing drug orders, including, but not limited to, the following:

i. The length of time drug orders may be in effect, for drugs not specifically limited as to duration of use or number of doses when ordered, including intravenous infusion solutions; and

ii. Notification of the prescriber by specified personnel and within a specified period of time prior to the expiration of a drug order to ensure that the drug is discontinued if no specific renewal is ordered;

11. Policies and procedures for the use of intravenous infusion solutions. The facility shall have an intravenous infusion admixture service operated by the pharmaceutical service. If the preparation, sterilization, and labeling of parenteral medications and solutions are performed in the exempt areas within the facility, as specified by facility policy, but not under direct supervision of a pharmacist, the pharmacist shall be responsible for providing written guidelines and for approving the procedures. Policies and procedures for the use of intravenous infusion solutions shall include, but not be limited to, the following:

i. Safety measures for the preparation, sterilization, and admixture of intravenous infusion solutions. These shall be prepared under a laminar air flow hood, except in patient care areas specified by facility policy;

ii. Quality control procedures for laminar air flow hoods, including cleaning of the equipment used on each shift, microbiological monitoring as required by the infection prevention and control policies and procedures of the facility, and documented checks at least every 12 months for operational efficiency; and

iii. Policies and procedures for the labeling of intravenous infusion solutions, such that a supplementary label is affixed to the container of any intravenous infusion solution to which drugs are added. The label shall include the patient's first and last name and room number; the name of the solution; the name and amount of the drug(s) added; the date and time of the addition; the date, time, and rate of administration; the name or initials of the pharmacy personnel who prepared the admixture; the name, initials, or identifying code of the pharmacist who prepared or supervised preparation of the admixture; supplemental instructions, including storage requirements; and the expiration date of the solution;

12. Policies and procedures for the storage of intravenous infusion solutions, which shall be stored according to a system of accountability specified in the facility's policies and procedures;

13. If facility policy permits, policies and procedures for drug research and the use of investigational drugs, in accordance with Federal and State rules and regulations;

14. Policies and procedures regarding the purchase, storage, safeguarding, accountability, use, and disposition of drugs, in accordance with New Jersey State Board of Pharmacy Rules, N.J.A.C. 13:39, and the Controlled Dangerous Substances Acts and amendments thereto;

15. Policies and procedures for the procurement, storage, use, and disposition of needles and syringes in accordance with the laws of the State of New Jersey and amendments thereto. There shall be a system of accountability for the purchase, storage, and distribution of needles and syringes. There shall be a system of accountability for the disposal of used needles and syringes which shall not necessitate the counting of individual needles and syringes after they are placed in the container for disposal;

16. Policies and procedures regarding the control of drugs subject to the Controlled Dangerous Substances Acts and amendments thereto, in compliance with the New Jersey State Board of Pharmacy Rules, N.J.A.C. 13:39, and all other Federal and State laws and regulations concerning procurement, storage, dispensing, administration, and disposition. Such policies and procedures shall include, but not be limited to, the following:

i. Provision for a verifiable record system for controlled drugs;

ii. Policies and procedures to be followed in the event that the inventories of controlled drugs cannot be verified or drugs are lost, contaminated, unintentionally wasted, or destroyed. A report of any such incident shall be written and signed by the persons involved and any witnesses present; and

iii. In all areas of the facility where drugs are dispensed, administered, or stored, procedures for the intentional wasting of controlled drugs, including the disposition of partial doses, and for documentation which includes the signature of a second person who shall witness the disposition;

17. Policies and procedures for the maintenance of records of prescribers' Drug Enforcement Administration numbers for New Jersey;

18. Specification of the information on drugs, their indications, contraindications, actions, reactions, interactions, cautions, precautions, toxicity, and dosage, to be provided in the pharmacy and in each nursing unit. Current antidote information and the telephone number of the regional poison control center shall also be provided in the pharmacy and in each nursing unit;

19. A list of abbreviations, metric apothecary conversion charts, and chemical symbols, approved by the medical staff, to be kept in each nursing unit; and

20. Policies and procedures concerning the activities of medical and pharmaceutical sales representatives in the facility. Drug samples shall not be accepted, placed or maintained in stock, distributed, or used in the facility.

8:43H-10.5 Inspection of premises

At intervals specified in the policy and procedure manual, a pharmacist shall inspect all areas in the facility where drugs are dispensed, administered, or stored, and shall maintain record of such inspections.

8:43H-10.6 Storage of drugs

(a) All drugs shall be stored and controlled in accordance with the New Jersey Board of Pharmacy rules at N.J.A.C. 13:39-9.

(b) The pharmacy shall maintain drugs under proper conditions, as indicated in the United States Pharmacopoeia, United States Pharmacopoeial Convention, USP DI--Volumes I-III, Micromedex, Inc. Publications, 6200 S. Syracuse Way, Suite 300, Englewood, CO 80111, incorporated herein by reference, as amended and supplemented, with appropriate product labeling and/or package inserts.

SUBCHAPTER 11. FOOD AND NUTRITIONAL SERVICES

8:43H-11.1 Provision for dietary services

The facility shall provide dietary services to meet the daily nutritional needs of patients, directly in the facility.

8:43H-11.2 Appointment of dietitian

(a) The facility shall appoint a dietitian who shall be responsible for the direction, provision, and quality of the food and nutritional service, and whose time shall be dedicated to the rehabilitation program as indicated by patient needs. The dietitian shall be responsible for, but not limited to, the following:

1. Developing and implementing written objectives, policies, a procedure manual, an organizational plan, and a quality improvement program for the food and nutritional service;

2. Participating in planning and budgeting for the food and nutritional service;

3. Ensuring that food and nutritional services are provided as specified in the interdisciplinary care plan and are coordinated with other patient care services to provide a continuum of care for the patient;

4. Assisting in developing and maintaining written job descriptions for food and nutrition personnel, and assigning duties based upon education, training, competencies, and job descriptions;

5. Participating in staff education activities and providing consultation to facility personnel.

6. Providing nutritional counseling.

8:43H-11.3 Food service supervisor

The facility shall appoint a full-time food service supervisor who functions under the guidance of a dietitian. A dietitian and/or food service supervisor shall be on duty seven days a week.

8:43H-11.4 Responsibilities of dietitians

(a) In accordance with written job descriptions, dietitians shall be responsible for providing dietary care, including, but not limited to, the following:

1. Ensuring that each patient is screened upon admission, assessing the dietary needs of the patient when indicated, preparing the food and nutrition components of the care plan based on the assessment, providing food and nutritional services as specified in the interdisciplinary care plan, reassessing the patient's response to services, and revising the food and nutritional components of the care plan. Each of these activities shall be documented in the patient's medical record;

2. As appropriate, participating as part of the interdisciplinary team in developing, implementing, reviewing, and revising the interdisciplinary care plan;

3. As indicated, writing clinical notes and progress notes; and

4. Assisting the patient in activities of daily living based upon the patient's strengths, needs, abilities, and preferences.

8:43H-11.5 Requirements for dietary services

(a) Dietary personnel shall be scheduled for a period of at least 12 hours daily.

(b) The dietary services shall comply with the provisions of N.J.A.C. 8:24.

(c) A current diet manual shall be available in the dietary service and in each nursing unit.

(d) Meal planning shall be in accordance with, but not limited to, the following:

1. Menus shall be prepared with regard for the nutritional and therapeutic needs, cultural backgrounds, food habits, and personal food preferences of patients;

2. Written, dated menus shall be planned at least 14 days in advance of all diets. The same menu shall not be used more than once in seven days; and

3. Current menus with portion sizes and any changes in menus shall be posted in the food preparation area. Menus, with changes, shall be kept on file in the dietary department for at least 30 days.

(e) Meal preparation and serving shall be in accordance with, but not limited to, the following:

1. Diets served shall be consistent with the diet manual and in accordance with physicians' orders;

2. Food shall be prepared by cutting, chopping, grinding, or blending to meet the needs of each patient;

3. At least three meals or their equivalent shall be prepared and served daily to patients. At least two meals shall contain three or more menu items, one of which shall be or shall include a high quality protein food such as meat, fish, eggs, or cheese. Each meal shall represent no less than 20 percent of the day's total calories, and at least 10 percent of the day's total calories shall be provided by protein.

4. Nutrients and calories shall be provided for each patient, as ordered by a physician, based upon current recommended dietary allowances of the Food and Nutrition Board of the National Academy of Sciences, National Research Council, adjusted for age, sex, weight, physical activity, and therapeutic needs of the patient;

5. Between-meal and bedtime nourishments shall be provided and beverages shall be available at all times for each patient, unless contraindicated by a physician as documented in the patient's medical record;

6. Substitute foods and beverages of equivalent nutritional value shall be available to all patients;

7. No more than 14 hours shall elapse between a substantial evening meal and breakfast the next morning. Up to 16 hours may elapse if the patient agrees to a nourishing bedtime snack, or a verbal offer of items, single or in combination, from the basic food groups; and

8. Designated staff shall be responsible for observing meals refused or missed and documenting the name of the patient and the meal refused or missed.

(f) A record shall be maintained, monitored and accessible for each patient, identifying the patient by name, location, diet order, and other information, such as meal patterns when on a calculated diet, and allergies.

SUBCHAPTER 12. PHYSICAL THERAPY, OCCUPATIONAL THERAPY, RESPIRATORY THERAPY, SPEECH-LANGUAGE PATHOLOGY, AUDIOLOGY SERVICES, AND THERAPEUTIC RECREATION

8:43H-12.1 Provision of physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology services

(a) The facility shall provide physical therapy, occupational therapy, respiratory therapy, speech-language pathology, audiology services and therapeutic recreation services directly in the facility to meet the rehabilitation needs of patients.

(b) Within 10 days of admission, the facility shall provide to each adult patient at least three hours of services per day, five days per week. Services shall include any one or any combination of the following as determined by the interdisciplinary team in collaboration with the patient and/or family:

1. Physical therapy;
2. Occupational therapy;
3. Speech-language pathology;
4. Respiratory therapy;
5. Therapeutic recreation; and/or
6. Psychology/social work.

(c) The facility shall provide to each pediatric patient the appropriate combination of rehabilitation therapy services as determined by the interdisciplinary team in collaboration with the patient and/or family. Rehabilitation therapy services may include physical therapy, occupational therapy, speech-language pathology, respiratory therapy, therapeutic recreation and any other service deemed appropriate by the interdisciplinary team.

8:43H-12.2 Appointment of physical therapist, occupational therapist, respiratory therapist, speech-language pathologist, and audiologist

(a) The facility shall appoint a physical therapist, occupational therapist, respiratory therapist, speech-language pathologist, and audiologist who shall be responsible for the direction, provision, and quality of the physical therapy, occupational therapy, respiratory therapy, speech-language pathology and audiology service, respectively. The physical therapist, occupational therapist, respiratory therapist, speech-language pathologist, and audiologist shall be responsible for, but not limited to, the following:

1. Developing and maintaining written objectives, policies, a procedure manual, an organizational plan, and a quality improvement program for the physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology service, respectively;

2. Participating in planning and budgeting for the physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology service, respectively;

3. Ensuring that services are provided as specified in the physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology care plan, respectively, and are coordinated with other patient care services to provide a continuum of care for the patient;

4. Assisting in developing and maintaining written job descriptions for physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology personnel, respectively, and assigning duties based upon education, training, competencies, and job descriptions; and

5. Participating in staff education activities and providing consultation to facility personnel.

8:43H-12.3 Responsibilities of physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology personnel

(a) In accordance with the State of New Jersey Physical Therapy Practice Act, N.J.S.A. 45:9-37.11 et seq., for physical therapy personnel, and in accordance with the State of New Jersey Audiology and Speech-Language Pathology Practice Act, N.J.S.A. 45:3B-1 et seq., for speech-language pathology and audiology personnel, and in accordance with the State of New Jersey Occupational Therapy Practice Act, N.J.S.A. 45:9-37.51 et seq., for the occupational therapist(s), and in accordance with the State of New JerseyRespiratory Care Practitioner Practice Act, N.J.S.A. 45:14E-1 et seq., for the respiratory therapist(s), and in accordance with written job descriptions, each physical therapist, occupational therapist, respiratory therapist, speech-language pathologist, or audiologist shall be responsible for providing patient care, including, but not limited to, the following:

1. Assessing the physical therapy, occupational therapy, respiratory therapy, speech-language pathology, or audiology needs, respectively, of the patient, preparing the interdisciplinary care plan based on the assessment, providing services as specified in the physical therapy, occupational therapy, respiratory therapy, speech-language pathology, or audiology care plan, respectively, reassessing the patient's response to services, and revising the care plan. Each of these activities shall be documented in the patient's medical record;

2. Participating as part of the interdisciplinary team in developing, implementing, reviewing, and revising the interdisciplinary care plan;

3. Writing clinical notes and progress notes; and

4. Assisting the patient in activities of daily living based upon the patient's strengths, needs, abilities and preferences.

SUBCHAPTER 13. COUNSELING SERVICES

8:43H-13.1 Provision of social work services and psychology services

The facility shall provide social work services and psychology services to patients directly in the facility.

8:43H-13.2 Appointment of social worker and psychologist

(a) The facility shall appoint a social worker who has a master's degree in social work and is licensed by the State Board of Social Work, and a psychologist. The social worker and the psychologist shall be responsible for the direction, provision, and quality of the social work service and psychology service, respectively. The social worker and the psychologist shall be responsible for, but not limited to, the following:

1. Developing and implementing written objectives, policies, a procedure manual, an organizational plan, and participating in the facility's quality improvement program for the social work service and psychology service, respectively;

2. Participating in planning and budgeting for the social work service and psychology service, respectively;

3. Ensuring that services are provided as specified in the social work care plan and psychology care plan, respectively, and are coordinated with other patient care services to provide a continuum of care for the patient;

4. Assisting in developing and maintaining written job descriptions for social work service personnel and psychology service personnel, respectively, and assigning duties based upon education, training, competencies, and job descriptions; and

5. Participating in staff education activities and providing consultation to facility personnel.

8:43H-13.3 Responsibilities of social worker and psychology staff

(a) In accordance with written job descriptions, each social worker or psychology staff member shall be responsible for providing patient care, including, but not limited to, the following:

1. When indicated, assessing the social work needs or psychological needs, respectively, of the patient, preparing the interdisciplinary care plan based on the assessment, providing services as specified in the interdisciplinary care plan, reassessing the patient's response to

services, and revising the interdisciplinary care plan. Each of these activities shall be documented in the patient's medical record;

2. Participating as part of the interdisciplinary team in developing, implementing, reviewing, and revising the interdisciplinary care plan; and

3. Writing clinical notes and progress notes.

SUBCHAPTER 14. THERAPEUTIC RECREATION SERVICES

8:43H-14.1 Provision of therapeutic recreation services

(a) When medically necessary and ordered by a physician the facility shall provide therapeutic recreation treatment services designed to restore, remediate or rehabilitate functional capabilities, as well as to reduce or eliminate the effect of illness or disability.

(b) The facility shall provide a planned, diversified program of recreational activities for patients, including daytime, evening, individual, group, and/or independent activities, on at least six days of the week, directly in the facility.

(c) Indoor and outdoor recreation shall be provided.

8:43H-14.2 Appointment of the individual overseeing therapeutic recreation

(a) The facility shall appoint an individual to oversee therapeutic recreation who shall be responsible for the direction, provision, and quality of the recreation therapeutic service. The individual overseeing therapeutic recreation shall be responsible for, but not limited to, the following:

1. Developing and implementing written objectives, policies, a procedure manual, and an organizational plan; and participating in the facility's quality improvement program;

2. Participating in planning and budgeting for the recreational therapy service;

3. Ensuring that services are provided as specified in the interdisciplinary care plan and are coordinated with other patient care services to provide a continuum of care for the patient;

4. Assisting in developing and maintaining written job descriptions for recreational therapy personnel, and assigning duties based upon education, training, competencies, and job descriptions;

5. Participating in staff education activities and providing consultation to facility personnel; and

6. Posting a current monthly recreational therapy activity calendar where it can be read by patients, staff, and visitors, and maintaining a record of such schedules for one year.

8:43H-14.3 Responsibilities of individuals overseeing therapeutic recreation

(a) In accordance with written job descriptions, each recreation therapist shall be responsible for providing patient care, including, but not limited to, the following:

1. Assessing the recreational therapy needs of the patient, preparing the therapeutic recreational component of the interdisciplinary care plan based on the assessment, providing recreational therapy services as specified in the interdisciplinary care plan, reassessing the patient's response to services, and revising the interdisciplinary care plan;

2. Participating as part of the interdisciplinary team in developing, implementing, reviewing, and revising the therapeutic recreational component of the interdisciplinary care plan;

3. Writing clinical notes and progress notes; and

4. Assisting the patient in activities of daily living based upon the patient's strengths, needs, abilities, and preferences.

SUBCHAPTER 15. ORTHOTIC AND PROSTHETIC SERVICES, VOCATIONAL TESTING, DRIVER TRAINING SERVICES, DENTAL SERVICES, LABORATORY AND RADIOLOGICAL SERVICES

8:43H-15.1 Provision of services

(a) The facility shall provide orthotic and prosthetic services, vocational services, and laboratory and radiological services to patients when indicated.

8:43H-15.2 Qualifications of personnel

(a) Orthotic and prosthetic services shall be provided by persons certified or eligible for certification by the American Board for Certification in Orthotics and Prosthetics, Inc.

(b) Vocational services shall be provided by a rehabilitation counselor.

8:43H-15.3 Provision of dental services

(a) Dental services shall be provided to patients, including, but not limited to, emergency dental care to relieve pain and infection.

(b) The facility, with consultation from a dentist, shall establish and implement written policies and procedures for dental services for patients and for staff education regarding dental care of patients.

(c) The dentist shall document in the patient's medical record all dental services provided, at the time services are provided.

8:43H-15.4 Provision of laboratory and radiological services

(a) Laboratory services shall be provided. Laboratories shall be licensed or approved by the Department.

(b) Radiological services shall be provided. Facilities providing radiological services shall maintain a current license and be approved by the New Jersey State Department of Environmental Protection, Bureau of Radiation Protection to operate.

SUBCHAPTER 16. EMERGENCY SERVICES AND PROCEDURES

8:43H-16.1 Emergency plans and procedures

(a) The facility shall have a written emergency plan which shall include plans and procedures to be followed in case of medical emergencies, equipment breakdown, fire, or other disaster.

(b) Procedures for emergencies shall specify persons to be notified, locations of emergency equipment and alarm signals, evacuation routes, procedures for evacuating patients, frequency of fire drills, and tasks and responsibilities assigned to all personnel.

(c) The emergency plans and all emergency procedures shall be conspicuously posted at wheelchair height throughout the facility. Personnel shall be trained in the location and use of emergency equipment in the facility.

8:43H-16.2 Drills and tests

(a) Simulated drills of emergency plans shall be conducted on each shift at least four times a year (a total of 12 drills) and documented, including the date, hour, description of the drill, participating staff, and signature of the person in charge. The four drills on each shift shall include at least one drill for emergencies due to fire. The facility shall conduct at least one drill per year for emergencies due to another type of disaster, such as storm, flood, other natural disaster, bomb threat, or nuclear accident.

(b) The facility shall test the emergency plan at random by at least one manual pull alarm three times per quarter and maintain documentation of test dates, location of each manual pull alarm tested, persons testing the alarm, and its condition.

(c) Fire extinguishers shall be examined annually and maintained in accordance with manufacturers' and National Fire Protection Association (N.F.P.A.) requirements.

SUBCHAPTER 17. PATIENT RIGHTS

8:43H-17.1 Policies and procedures regarding patient rights

(a) The operations manager accountable for rehabilitation services shall establish and implement written policies and procedures regarding the rights of patients. These policies and procedures shall be available to patients, staff, and the public and shall be conspicuously posted in the facility.

(b) The staff of the facility shall be trained to implement policies and procedures regarding patient rights.

(c) The facility shall comply with all applicable State and Federal statutes and rules concerning patient rights, including N.J.S.A. 52:27G-7.1. The State Office of the Ombudsman for the Institutionalized Elderly shall be notified of any suspected patient abuse or exploitation pursuant to N.J.S.A. 52:27G-7.1, if the patient is 60 years of age or older.

8:43H-17.2 Rights of each patient

(a) Each patient shall be entitled to the following rights, none of which shall be abridged or violated by the rehabilitation hospital or any of its staff:

1. To treatment and services without discrimination based on race, age, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay, or source of payment;

2. To be given, prior to the initiation of care, a written copy of the patient rights set forth in this subchapter and any additional policies and procedures established by the facility involving patient rights and responsibilities. If the patient is unable to respond, the notice shall be given to a family member or an individual who is a legal representative of the patient;

3. To be informed in writing of the following:

i. Services available from the rehabilitation hospital;

ii. The names and professional status of personnel providing and/or responsible for care; and

iii. Information regarding the filing of complaints with the New Jersey Department of Health and Senior Services, including the telephone number for the 24-hour Complaint Hotline at 1-800-792-9770, and the address for written complaints:

New Jersey Department of Health and Senior Services
Inspection, Compliance and Complaints Program
PO Box 360, Room 601
Trenton, New Jersey 08625-0360

4. To receive, in terms that the patient understands, an explanation of his or her plan of care, its expected results, and reasonable alternatives. If this information would be detrimental to the patient's health, or if the patient is not able to understand the information, the explanation shall be provided to a family member or an individual who is a legal representative of the patient and so documented in the patient's medical record;

5. To receive, as soon as possible, the services of a translator or interpreter to facilitate communication between the patient and health care personnel;

6. To receive the care and health services that have been ordered;

7. To participate in the planning of his or her rehabilitation care and treatment;

8. To refuse services, including medication and treatment, provided by the facility and to be informed of available rehabilitation hospital treatment options, including the option of no treatment, and of the possible benefits and risks of each option;

9. To refuse to participate in experimental research. If he or she chooses to participate, his or her written informed consent shall be obtained;

10. To receive full information regarding financial arrangements, including, but not limited to:

i. Fees and charges, including any fees and charges for services not covered by sources of third party payment;

ii. Copies of written records of financial arrangements;

iii. Notification of any additional charges, expenses, or other financial liabilities in excess of the predetermined fee; and

iv. A description of agreements with third-party payors and/or other payors and referral systems for patients' financial assistance;

11. To express grievances regarding care and services to the rehabilitation hospital's staff and governing authority without fear of reprisal, and to receive an answer to those grievances within a reasonable period of time;

12. To be free from mental and physical abuse and from exploitation;

13. To be free from restraints, unless they are authorized by a physician for a limited period of time to protect the patient or others from injury;

14. To be assured of confidential treatment of his or her medical/health record, including the opportunity to approve or refuse in writing its release to any individual outside the rehabilitation hospital, except as required by law or third party payment contract;

15. To be treated with courtesy, consideration, respect, and recognition of dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy and confidentiality concerning patient treatment and disclosures;

16. To be assured of respect for the patient's personal property;

17. To retain and exercise to the fullest extent possible all the constitutional, civil, and legal rights to which he or she is entitled by law, including religious liberties, the right to independent personal decisions, and the right to provide instructions and directions for health care in the event of future decision making incapacity in accordance with the New Jersey Advance Directives for Health care Act, N.J.S.A. 26:2H-53 et seq., and any rules which may be promulgated pursuant thereto;

18. To be informed by the attending physician and other providers of health care services about any continuing health care requirements after the patient's discharge from the hospital. The patient shall also have the right to receive assistance from the physician and appropriate hospital staff in arranging for required follow-up care after discharge;

19. To receive sufficient time before discharge to make arrangements for health care needs after hospitalization;

20. To be informed by the hospital about any discharge appeal process to which the patient is entitled by law;

21. To be transferred to another facility only for one of the following reasons, with the reason recorded in the patient's medical record.

i. The transferring hospital is unable to provide the type or level of medical care appropriate for the patient needs. The hospital shall make an immediate effort to notify the patient's primary care physician and the next of kin, and document that the notifications were received; or

ii. The transfer is requested by the patient, or by the patient's next of kin or guardian when the patient is mentally incapacitated or incompetent;

22. To receive from a physician an explanation for the transfer to another facility, information about alternatives to the transfer, verification of acceptance from the receiving facility, and assurance that the movement associated with the transfer will not subject the patient to substantial, unnecessary risk of deterioration of his or her medical condition. This explanation

of the transfer shall be given in advance to the patient, and/or to his or her next of kin or guardian except in a life-threatening situation where immediate transfer is necessary;

23. To have prompt access to the information contained in his or her medical record, unless a physician prohibits such access as detrimental to the patient's health, and explains the reason in the medical record. In that instance, the patient's next of kin or guardians shall have a right to see the record. This right continues after the patient is discharged from the hospital for as long as the hospital has a copy of the record; and

24. To obtain a copy of the patient's medical record, at a reasonable fee, within 30 days of a written request to the hospital. If access by the patient is medically contraindicated (as documented by a physician in the patient's medical record), the medical record shall be made available to a legally authorized representative of the patient or the patient's physician.

SUBCHAPTER 18. CASE MANAGEMENT AND DISCHARGE PLANNING SERVICES

8:43H-18.1 Discharge plan

(a) The facility plan shall provide discharge planning services to patients.

(b) Each patient shall have a discharge plan. Discharge planning shall be initiated within 24 hours of the patient's admission. Plans for discharge shall be reviewed and revised.

(c) The patient and, if indicated, family members shall participate in developing and implementing the patient discharge plan. Participation shall be documented in the patient medical record.

(d) The discharge plan shall include instructions given to the patient and/or his or her family for care following discharge.

8:43H-18.2 Discharge planning policies and procedures

(a) Written policies and procedures shall be established and implemented for discharge planning services, which shall describe:

1. The functions of the person or persons responsible for planning, providing, and/or coordinating discharge planning services;

2. The time period for completing each patient's discharge plan;

3. The time period that may elapse before a reevaluation of each patient's discharge plan is made;

4. Use of the interdisciplinary team in discharge planning;

5. Criteria for patient discharge; and

6. Methods of patient and family involvement in developing and implementing the discharge plan.

SUBCHAPTER 19. MEDICAL RECORDS

8:43H-19.1 Maintenance of medical records

(a) A current medical record shall be maintained for each patient and shall contain documentation of all services provided.

(b) Written objectives, policies, a procedure manual, an organizational plan, and a quality assurance program for medical record services shall be developed and implemented.

(c) A record system shall be maintained in which the patient's complete medical record is filed as one unit in one location within the facility.

8:43H-19.2 Assignment of responsibility

Responsibility for the medical record service shall be assigned to an employee who, if not a medical record practitioner, functions in consultation with a person so qualified.

8:43H-19.3 Contents of medical records

(a) The patient medical record shall include, but not be limited to, the following:

1. Patient identification data, including name, date of admission, address, date of birth, race and religion (optional), sex, referral source, payment plan, marital status, and the name, address, and telephone number of the person(s) to be notified in an emergency;

2. The patient's signed acknowledgement that he or she has been informed of and given a copy of patient rights;

3. Documentation of the patient's orientation to the facility;

4. Documentation of the medical history and physical examination, signed and dated by the physician;

5. An interdisciplinary care plan, signed and dated by the physician;

6. Patient assessments for each service providing care to the patient;

7. Clinical notes and progress notes;

8. Documentation of the patient's participation in his or her interdisciplinary care plan, or documentation by a physician that the patient's participation is medically contraindicated;

9. A record of medications administered, including the name and strength of the drug, date and time of administration, dosage administered, method of administration, and signature of the person who administered the drug;

10. A record of self-administered medications, if the patient self- administers medications, in accordance with the facility's policies and procedures;

11. Documentation of allergies in the medical record and on its outside front cover;

12. Documentation of environmental assessment services;

13. Documentation of orthotic and prosthetic services, vocational services, laboratory and radiological, and dental services;

14. A record of referrals to other health care providers;

15. Documentation of consultations;

16. A record of the clothing, personal effects, valuables, funds, and other property deposited by the patient with the facility for safekeeping, signed by the patient or his or her family, and substantiated by receipts given to the patient or his or her family;

17. Any signed written informed consent forms;

18. Documentation of the existence, or nonexistence, of an advance directive and the facility's inquiry of the patient concerning this;

19. A record of any treatment, drug, or service offered by personnel of the facility and refused by the patient;

20. Documentation of injuries, accidents, incidents, or death;

21. The discharge plan; and

22. The discharge summary, in accordance with N.J.S.A. 26:8-5 et seq.

8:43H-19.4 Requirements for entries

(a) All orders for patient care shall be prescribed in writing and signed and dated by the prescriber, in accordance with the laws of the State of New Jersey.

(b) All entries in the patient medical record shall be legible and signed and dated by the person entering them.

8:43H-19.5 Medical records policies and procedures

(a) The facility shall establish and implement written policies and procedures regarding medical records including, but not limited to, policies and procedures for the following:

1. The protection of medical record information against loss, tampering, alteration, destruction, or unauthorized use. The patient's consent shall be obtained for release of medical record information;

2. The specific period of time in which the medical record shall be completed following patient discharge, and disciplinary action for noncompliance;

3. The transfer of patient information when the patient is transferred to another health care facility, or if the patient becomes an outpatient at the same facility, including a copy of the patient's advance directive, if available, or notice that the patient has informed the sending facility of the existence of an advance directive; and

4. The release and/or provision of copies of the patient's medical record to the patient and/or the patient's authorized representative. Such written policies and procedures shall include, but not be limited to, the following:

i. Establishment of a fee schedule for obtaining copies of the patient's medical record;

ii. Policies and procedures regarding patient access to his or her medical record during business hours;

iii. Policies and procedures regarding availability of the patient's medical record to the patient's authorized representative if it is medically contraindicated (as documented by a physician in the patient's medical record) for the patient to have access to or obtain copies of the record; and

iv. Procedures to ensure that the patient's medical record is provided within 30 calendar days of the written request.

8:43H-19.6 Preservation, storage, and retrieval of medical records

(a) All medical records shall be preserved in accordance with N.J.S.A. 26:8-5 et seq.

(b) If the facility plans to cease operations, it shall notify the Department in writing, at least 14 days before cessation of operation, of the location where medical records shall be stored and of methods for their retrieval.

SUBCHAPTER 20. INFECTION PREVENTION AND CONTROL SERVICES

8:43H-20.1 Responsibility of the operations manager accountable for rehabilitation services

(a) The operations manager responsible for rehabilitation services shall ensure the development and implementation of an infection prevention and control program.

(b) There shall be an infection control professional who is responsible for the coordination of the infection control program.

1. The infection control professional shall have education or training in surveillance, prevention, and control of nosocomial infections. The infection control professional shall be certified in infection control within five years of beginning practice of infection control activities and shall maintain certification thereafter through the Certification Board of Infection Control (CBIC).

8:43H-20.2 Infection control policies and procedures

(a) Each service in the facility shall develop written policies and procedures for the infection control program for that service.

(b) The infection control professional who is responsible for the infection control program shall implement the following mandatory requirements, but may implement additional infection control methods, as deemed necessary and appropriate by the facility:

1. Formulation of a system for surveillance of nosocomial infection, as follows:

i. Identification and description of the infection event to be studied;

ii. Definition of the population at risk;

iii. Identification of data sources, data collection methods, and data collection personnel;

iv. Selection of appropriate statistical methods of measurement;

v. Establishment of an attack rate. An attack rate is defined as the total number of people who show infection from the total numbers of people exposed to the infection; and

vi. Preparation and distribution of conclusionary reports to appropriate quality assurance personnel and departments involved in the study;

2. Methods for the prevention and control of nosocomial infections shall be implemented and based on the most recently published guidelines from the Centers for Disease Control and Prevention as well as the recommendations from the Hospital Infection Control Practices Advisory Committee (that is, HICPAC), and any amendments or supplements thereto, incorporated herein by reference, as follows:

i. Guidelines for Prevention of Catheter-Associated Urinary Tract Infections, PB84-923402;

ii. Guidelines for Prevention of Intravascular Device-Related Infections, PB97-130074;

iii. Guidelines for Prevention of Surgical Wound Infections, PB85-923403;

iv. Guidelines for Prevention and Control of Nosocomial Pneumonia, PB95- 176970;

v. Guidelines for Handwashing and Hospital Environmental Control, PB85- 923404;

vi. Guidelines for Infection Control in Hospital Personnel CDC, PB99-105454;

vii. Guidelines for Isolation Precautions in Hospitals (Infection Controland Hospital Epidemiology 1996; 17:53-80 and the American Journal of Infection Control 1996; 24:24-52);

viii. Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis In Health Care Facilities (Morbidity and Mortality Weekly Report 1994; 43-11-22); and

ix. Hospital Infection Control Practices Advisory Committee Recommendations for Preventing the Spread of Vancomycin Resistance;

3. The guidelines listed in (b)2 above are available from the National Technical Information Service (NTIS) by calling 1-800-553-6847 or writing the NTIS, 5285 Port Royal Road, Springfield, Virginia 22161. The complete set of the seven guidelines for the Prevention and Control of Nosocomial Infections are listed under the publication number: PB86133022. Further information is available on the Centers for Disease Control and Prevention/National Center of Infectious Diseases' web site at: http://www.cdc.gov/ncidod/hip. The HICPAC Recommendations for Preventing the Spread of Vancomycin Resistance is available on CDC web site at: http://www.cdc.gov/ncidod/vancom.htm;

4. An exception to the use of the guidelines referenced in (b)2 above is permitted, provided there is an infection control rationale which meets minimum acceptable standards within the industry and which shall be based upon scientific research and epidemiological data. (Example: CDC, Morbidity and Mortality Weekly Report (MMWR));

5. Review, at least every three years, of the hospital's policies and procedures related to infection control, including, but not limited to standard precautions/isolation of infected patients, aseptic technique, employee health, and staff training;

6. Identification and reporting of communicable diseases existing throughout the hospital, through information obtained from the clinical laboratory, medical records, and the medical staff, as specified in N.J.A.C. 8:57-1, Communicable diseases, also known as Chapter II of the State Sanitary Code; and

7. Identification and reporting of HIV/AIDS existing throughout the hospital, as specified in N.J.A.C. 8:57-2.7, Reporting of acquired immunodeficiency syndrome and infection with human immunodeficiency virus.

(c) The following concern infection prevention and control responsibility:

1. Orientation for all new employees shall include instruction on infection control practices related to blood and other bodily fluid precautions, education on safe isolation practices for infected patients, tuberculosis education, and use of protective vaccines. Additional infection control orientation shall focus on the employees' specific areas of service.

2. The infection control professional shall coordinate educational programs to address specific infection control problems.

3. The infection control professional shall develop policies and procedures to educate employees and patients on latex allergy management, in coordination with the hospital's employee health department.

4. The infection control professional shall report problems, data, and relevant recommendations to staff in the quality improvement program, nursing service, administration, and the medical department, and shall ensure corrective action.

5. A system of infection control and isolation procedures, including Universal/Standard Precautions, shall be developed and implemented using criteria which meet or exceed the criteria established by the Centers for Disease Control and Prevention and Occupational Safety and Health Administration Publication, "29 CFR 1910030 Bloodborne Pathogens."

(d) Between October 1, or earlier if the vaccination is available, and February 1 of every year, provided a patient's medical condition permits, every patient aged 65 or older shall be provided the opportunity to receive vaccination against influenza, in accordance with the recommendation of the Advisory Committee on Immunization Practices of the Centers for Disease Control in effect at the time, incorporated herein by reference. Receipt of the vaccination shall be documented on the patient's chart and made a part of the patient's permanent hospital record. Prior to administration of the vaccination, diligence should be exercised to determine whether the patient has already received the influenza vaccination for the year in question.

1. Centers for Disease Control publications can be obtained from:

Superintendent of Documents
U.S. Government Printing Office
Washington, DC 20402

(e) As soon as a patient's medical condition permits, every patient aged 65 years or older shall be provided the opportunity to receive vaccination against pneumococcal disease, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control in effect at the time, incorporated herein by reference. Receipt of the vaccination shall be documented on the patient's chart and made a part of the patient's permanent hospital record. Prior to administration of the vaccination, diligence should be exercised to determine whether the patient has received the pneumococcal vaccination within the preceding 10 years. Centers for Disease Control publications can be obtained from the address in (c)1 above.

(f) Patients refusing either or both the influenza and/or pneumococcal vaccine(s) shall be requested to sign a form indicating that the vaccine was offered, but refused. The form shall contain all relevant patient identification information. In the event the patient refuses to sign the form, the form shall so indicate. The refusal shall be documented on the patient's chart and made part of the patient's permanent hospital record. The refusal form shall also become a part of the patient's permanent hospital record.

(g) Hospitals shall collect data regarding patient influenza and pneumococcal immunization and shall report that data to the Department on an annual basis, beginning July 1, 2000, for year 1999 data. The data shall be limited to the number of patients aged 65 and older receiving the influenza vaccine and the number of patients aged 65 and older receiving the pneumococcal vaccine.

8:43H-20.3 Environmental aspects of infection control

(a) Disinfection and sterilization of patient care items or equipment shall be implemented as follows:

1. Critical items, that is, objects that enter sterile tissue or the vascular system, shall be sterilized by a process that can demonstrate a kill rate of 10.

2. Semicritical items, that is, objects that come in contact with mucous membranes or with skin that is not intact, require high level disinfection or intermediate level disinfection; at a minimum, the disinfectant shall inactivate Mycobacterium Tuberculosis.

3. Noncritical items that come in contact with intact skin but not with mucous membranes require low level disinfection; emphasis shall be placed on cleaning of appropriate surfaces.

(b) Methods for processing reusable medical devices shall conform with the following standards; if revised or later editions are in effect, they are incorporated herein by reference:

1. The Association for the Advancement of Medical Instrumentation (AAMI) requirements for good hospital practice steam sterilization and sterility assurance, AAMI, St (Standard) 46, Steam Sterilization and Sterility Assurance, 3rd Edition, 1993, AAMI, 3330 Washington Boulevard, Suite 400, Arlington, VA 22201; and

2. The Association for the Advancement of Medical Instrumentation (AAMI) requirements for safe use and handling of gultaraldehyde-based products in health care facilities, AAMI, St. 58, Safe Handling and Use of Gultaraldehyde Based Products in Health Care Facilities, 1996.

(c) Single-use items shall be reused or reprocessed only if the manufacturer provides written documentation of validation of processes related to reuse or reprocessing, or if the hospital has scientific validation of the safety of reprocessing and reuse of the item. Procedures for reprocessing and reuse shall conform with these recommendations or validation studies.

1. The validation studies shall demonstrate that the sterilization process is efficacious, and the integrity of the item is not compromised; the number of reuses that can safely be performed shall be specified.

2. Should the hospital outsource the reprocessing of a single-use item to a third party reprocessor, a certificate of registration with the Food and Drug Administration shall be provided to ensure compliance with good manufacturing practices.

i. Validation studies as described at (c) above shall be provided for each single-use item that is reprocessed by a third party reprocessor and maintained on site for at least three years.

ii. A quality assurance program shall be established to ensure the delivery of a safe product as specified in the contract with the third party reprocessor.

SUBCHAPTER 21. HOUSEKEEPING, SANITATION, AND SAFETY

8:43H-21.1 Provision of services

(a) The housekeeping services shall have written policies and procedures that are reviewed every three years, implemented and revised as needed. The policies and procedures shall address, at a minimum, scope of responsibility, assignment by designated unit, and responsibility for cleaning tasks.

(b) The housekeeping services shall have a written schedule that determines the frequency of cleaning for all equipment, structures, areas, and systems within its scope of responsibility.

(c) The housekeeping services shall have an education or training program for all housekeeping employees with documented course content and attendance records maintained on site.

8:43H-21.2 Housekeeping equipment and supplies

(a) Cleaning agents used in the facility shall be approved by the housekeeping service and the infection control professional.

(b) All cleaning and disinfecting agents shall be correctly labeled with the name of the product and its use, including agents that have been repackaged from a bulk source.

(c) There shall be a list available at all times of all cleaning and disinfecting agents used in the hospital. Material Safety Data Sheets (MSDS) shall be available at all times for all agents.

(d) Housekeeping and cleaning products shall be selected, diluted, and used according to manufacturer's instructions.

8:43H-21.3 Patient care environment

(a) The following environmental surfaces shall be maintained as follows:

1. Hard surfaced floors shall be coated with a slip-resistant floor finish.

2. Hard surfaced floors shall be kept clean.

3. Carpeting shall be kept clean and odor free and shall not be frayed, worn, torn, or buckled.

i. HEPA filters shall be provided on vacuums used for carpet care within the facility.

4. Walls shall be cleaned of spills and splashes as necessary.

5. Ceilings and vents shall be clean to sight and touch.

6. Windows and screens shall be kept clean to sight and touch, and in good repair.

7. Window and partitioning curtains and drapes shall be kept clean to sight and touch.

8. All furnishings shall be clean and in good repair; broken or worn items shall be repaired, replaced, or removed promptly.

9. Mattresses, mattress pads and coverings, and pillows, shall be properly maintained and kept clean.

10. All areas, including areas with limited access such as cabinets, drawers, locked medication rooms, and storage areas, shall be kept clean to sight and touch.

11. All portable equipment shall be properly maintained and kept clean.

12. Building and grounds shall be maintained in a clean and safe condition.

(b) The facility shall provide a pest control program that includes the following:

1. Effective and safe controls shall be used to minimize or eliminate the presence of rodents, flies, roaches, and other vermin in the hospital. The premises shall be kept in such condition as to prevent the breeding, harboring, or feeding of vermin.

2. Records of all pesticides and herbicides used at the hospital shall be maintained on-site, together with MSDS sheets for all products.

3. Pest control measures shall be undertaken pursuant to the requirements of the New Jersey Pesticide Control Rules, N.J.A.C. 7:30.

(c) Solid waste and regulated medical waste management shall comply with the following:

1. The hospital shall comply with provisions of the Comprehensive Regulated Medical Waste Management Act at N.J.S.A. 13:1E-48.1 et. seq., and all rules promulgated pursuant thereto.

2. Solid waste shall be stored within the containers provided for it in an area that is kept clean. Waste shall be collected from storage areas regularly to prevent nuisances such as odors, flies, rodents or other vermin, and so that waste does not overflow or accumulate beyond the capacity of the storage containers.

3. Plastic bags shall be used for solid waste removal from patient care units and support departments. Bags shall be of sufficient strength to safely contain waste from point of origin to point of disposal and shall be effectively closed prior to disposal.

4. Where the separation of solid waste and recyclables is required by local ordinance, policies and procedures shall be established to ensure appropriate collection, storage, transportation and disposal of recyclables, to maintain them clean and odor-free; and to prevent the breeding of insects or vermin.

5. Outside storage containers for solid waste shall be kept covered, except those used for corrugated cardboard, recyclables, or construction materials.

6. Garbage compactors shall be located on an impervious pad that is graded to a drain. The drain shall be kept clean and shall be connected to the sanitary sewage disposal system.

(d) The following patient safety issues shall be followed:

1. The temperature of the hot water used for showers, bathing and hand washing shall be maintained between 95 and 110 degrees Fahrenheit, and cold running water shall be provided in patient care areas.

2. The water supply shall be adequate in quantity and safe and sanitary in quality. The water system must be constructed, protected, operated, and maintained in conformance with the New Jersey Safe Drinking Water Act, N.J.S.A. 58:12A-1 et seq. and N.J.A.C. 7:10 and other applicable laws, ordinances, rules and regulations.

i. The Safe Drinking Water Act and rules can be obtained from:

Department of Environmental Protection
Bureau of Safe Drinking Water
PO Box 426
Trenton, New Jersey 08625-0426

3. The ambient temperature in the facility shall be kept between 70 degrees Fahrenheit and 75 degrees Fahrenheit at all times.

(e) Therapeutic swimming pools must comply with the following sections of N.J.A.C. 8:26, Public Recreational Bathing.

1. Water quality criteria specified in N.J.A.C. 8:26-7; and

2. Emergency equipment specified in N.J.A.C. 8:26-5.

8:43H-21.4 Linen and laundry services

(a) The laundry service shall have written policies and procedures which are reviewed every three years, implemented and revised as needed. At a minimum, the following procedures shall be established:

1. Policies and procedures shall be established for the collection and transport of linen and clothing to avoid microbial dissemination into the environment.

2. If the hospital has an in-house laundry, an established protocol shall be followed to reduce the number of bacteria in the fabrics during the wash cycle.

3. A protocol shall be established to ensure that patients' personal clothing is properly identified, collected, laundered and returned to the appropriate patient.

4. The hospital shall establish a par level to ensure an adequate supply of sheets, pillowcases, drawsheets, blankets, towels, and wash cloths.

5. A written schedule of staff training programs shall be established and documented regarding course content and attendance, and it shall be maintained on-site.

(b) The following concern laundry space and environment:

1. If a laundry chute is used, it shall be kept locked, maintained in good repair and cleaned to avoid a build-up of visible soil.

2. All equipment used to transport and store linen shall be maintained in good repair and cleaned to avoid a build-up of visible soil.

3. The walls, floor and ceiling of the laundry processing areas shall be kept clean and in good repair.

(c) The following concern laundry quality assurance methods:

1. Hospitals that contract with a commercial laundry service shall use quality assurance measures to ensure that the standards of this section are met.

2. The laundry service shall monitor at least the following:

i. pH;

ii. Unsafe objects found; and

iii. Stained, torn or worn linens;

3. If using built detergents, sour testing shall be performed to indicate the degree of acidity or alkalinity of lines. Fabric shall be maintained at a ph below 7.0 after souring.

SUBCHAPTER 22. QUALITY IMPROVEMENT PROGRAM

8:43H-22.1 Quality improvement plan

The facility shall establish and implement a written plan for a quality assurance program for patient care. The plan shall specify a timetable and the person(s) responsible for the quality improvement program and shall provide for ongoing monitoring of staff, clinical competencies and patient care services.

8:43H-22.2 Quality improvement activities

(a) Quality improvement activities shall include, but not be limited to, the following:

1. At least annual review of staff and a three year review of physician qualifications, credentials and clinical competence;

2. At least annual review of staff orientation and staff education;

3. Evaluation of patients' needs, expectations and satisfaction; results of infection control activities; safety of the care environment and utilization management; and risk management findings and actions taken;

4. Evaluation by patients and their families of care and services provided by the facility;

5. Audit of patient medical records (including those of both active and discharged patients) on an ongoing basis to determine if care provided conforms to criteria established by each patient care service for the maintenance of quality of care; and

6. Establishment of a patient care outcome assessment system using industry accepted indicators for evaluation of the rehabilitation care provided by each service, which includes criteria to be used for the determination of achievement of patient rehabilitation goals.

8:43H-22.3 Measures for corrections and improvements

The results of the quality assurance program shall be submitted to the governing authority at least annually and shall include at least deficiencies found and recommendations for corrections or improvements. Deficiencies which jeopardize patient safety shall be reported to the governing authority immediately. The operations manager accountable for rehabilitation services shall, with the approval of the governing authority, implement measures to ensure that corrections or improvements are made.

SUBCHAPTER 23. PHYSICAL PLANT

8:43H-23.1 Standard for construction, alteration, or renovation of rehabilitation facilities

(a) Standards for construction of rehabilitation facilities in new buildings, additions, alterations and renovations to existing buildings shall be in accordance with the New Jersey Uniform Construction Code, N.J.A.C. 5:23 under Use Group I-2 and standards imposed by the United States Department of Health and Human Services (HHS), the Americans with Disabilities Act, 42 U.S.C. § § 12101 et seq., the New Jersey Departments of Health and Senior Services and Community Affairs, and the Guidelines for Construction and Equipment of Hospital and Medical Facilities, 1987 Edition as published by The American Institute of Architects Press. In order to avoid conflict between N.J.A.C. 5:23 and the other standards listed above, Sections 501.3, 610.4.1, 704.0, 705.0, 706.0, 708.0 and 916.5 of the 1987 BOCA Basic Building Code of the New Jersey Uniform Construction Code shall not govern with respect to health care facilities.

SUBCHAPTER 24. FUNCTIONAL REQUIREMENTS

8:43H-24.1 Provisions for the handicapped

Facilities shall be available and accessible to the physically handicapped, pursuant to the Americans with Disabilities Act (ADA), 42 U.S.C. § § 12101 et seq., and New Jersey Uniform Construction Code, N.J.A.C. 5:23-7, Barrier free subcode.

8:43H-24.2 Functional service areas

(a) Each rehabilitation facility shall have the following service areas on site or available if applicable:

1. Medical evaluation services;
2. A psychology service with sexual counseling services;
3. Social work services;
4. Vocational services;
5. Recreation therapy services;
6. Respiratory therapy services;
7. Dietary services with nutritional counseling;
8. Administration services;
9. Nursing services;
10. Physical therapy services;
11. Occupational therapy services with environmental modification services, driver evaluation services and activities of daily living services;
12. Orthotic and prosthetic services;
13. Speech-language pathology and audiology services;
14. Radiology services;
15. Laboratory services;

16. Pharmacy services;

17. Sterilization services;

18. Linen services;

19. Housekeeping services;

20. Employees facilities;

21. Engineering service and equipment areas; and

22. Educational services.

(b) Each rehabilitation facility shall also comply with the requirements for details and finishes set forth at N.J.A.C. 8:43H-24.26 and 24.27.

8:43H-24.3 Medical evaluation services

(a) The medical evaluation service shall include the following:

1. Offices for personnel; and

2. Examination rooms, which shall have a minimum floor area of 120 square feet, excluding such spaces as the vestibule, toilet, closet, and work counter (whether fixed or movable). The minimum room dimension shall be 10 feet. The room shall contain a lavatory or sink equipped for handwashing, a work counter, storage facilities and a desk, counter, or shelf space for writing.

8:43H-24.4 Psychology services

The psychology services unit shall include offices and workspace for testing, evaluation and counseling.

8:43H-24.5 Social work services

The social work services unit shall include office space(s) for private interviewing and counseling, waiting space, record storage space and secretarial office space.

8:43H-24.6 Vocational services

The vocational services unit shall contain office(s) and workspace for evaluation, counseling and placement.

8:43H-24.7 Patient dining, recreation therapy and day spaces

(a) Patient dining, separate from the patient's room, shall be allocated. Patient dining, therapeutic recreation, and day spaces may be in separate or adjoining spaces and it shall be permissible for both dining and recreation to occur simultaneously.

(b) For inpatients and residents, a total of 30 square feet per bed for the first 100 beds and 27 square feet per bed for all beds in excess of 100 shall be provided for patient dining, recreation therapy and day spaces.

(c) An indoor and an outdoor recreation area shall be provided.

(d) For outpatients in medical day and/or day hospitalization, a total of 20 square feet per person shall be provided, if dining is part of the day care program. If dining is not part of the program, at least 10 square feet per person for recreation and day spaces shall be provided.

(e) Storage spaces shall be provided for recreational equipment and supplies.

(f) An office for the recreation therapist shall be provided.

8:43H-24.8 Respiratory therapy services

(a) Respiratory therapy services may be provided as a separate area or at the patient's bedside.

1. A separate area shall include:

   i. Office and clerical space;

   ii. Convenient access to staff toilets, lounge, lockers and showers;

   iii. Access to a conference room;

   iv. Storage for equipment and supplies; and

   v. Space and utilities for cleaning and sanitizing equipment.

2. If respiratory therapy services are provided at the patient's bedside, there shall be storage in the patient's room for equipment and supplies.

8:43H-24.9 Dietary services and nutritional counseling

(a) The construction, equipment, and installation of food service facilities shall meet the requirements of the functional program. Services may consist of an onsite conventional food preparation system, a convenience food service system, or an appropriate combination thereof. The following facilities shall be provided as required to implement the food service selected:

1. Storage facilities for four days' food supply, including cold storage items;

2. Food preparation facilities as follows:

i. Conventional food preparation systems with space and equipment for preparing, cooking, and baking;

ii. Convenience food service systems; such as frozen prepared meals, bulk packaged entrees, individually packaged portions, and contractual commissary services with space and equipment for thawing, portioning, cooking, and/or baking;

3. Handwashing facility(ies) located in the food preparation area;

4. Patient meal service facilities for tray assembly and distribution;

5. Dining space for staff and visitors;

6. Commercial dishwashing and tableware washing equipment shall be provided and located in a room or an alcove separate from food preparation and serving areas. Space shall also be provided for receiving, scraping, sorting, and stacking soiled tableware and separate area for transferring clean tableware to the using areas. A lavatory shall be conveniently available;

7. Potwashing facility(ies);

8. Storage areas or cans, carts, and mobile tray conveyors;

9. Waste storage facility(ies) shall be located in a separate room easily accessible to the outside for direct waste pickup or disposal. A janitor's closet shall be located within the food and nutrition services department and shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies;

10. Office(s) or desk space(s) for dietitian(s) or the dietary service manager;

11. Toilets for dietary staff with handwashing facility(ies), which shall be immediately available; and

12. Self-dispensing icemaking facilities, which may be in an area or room separate from the food preparation area, but must be easily cleanable and convenient to dietary facilities.

(b) Nutritional counseling shall be provided in a location which ensures a patient's privacy.

8:43H-24.10 Administration services

(a) A grade-level entrance, sheltered from the weather and able to accommodate wheelchairs, shall be provided which conforms to the requirements of N.J.A.C. 5:23-7.

(b) A lobby shall be provided which shall include:

1. Wheelchair storage space(s);

2. A reception and information counter or desk;

3. Waiting space(s);

4. Public toilet facility(ies);

5. Public telephone(s); and

6. Drinking fountain(s).

(c) Interview space(s) for private interviews relating to social service, credit, and admissions shall be provided.

(d) General or individual office(s) for business transactions, records, and administrative and professional staffs shall be provided.

(e) Multipurpose room(s) shall be provided for conferences, meetings, health education, and library services.

(f) Storage shall be provided for employee's personal effects.

(g) Separate space for office supplies, sterile supplies, pharmaceutical supplies, splints and other orthotic supplies, and housekeeping supplies and equipment shall be provided.

8:43H-24.11 Nursing services

(a) Each patient room shall meet the following requirements:

1. Maximum room occupancy shall be four patients. At least two private rooms with private toilet rooms shall be provided for each nursing unit.

2. Each patient shall have a minimum room area exclusive of toilet rooms, closets, lockers, wardrobes, alcoves, or vestibules of 125 square feet in single-bed rooms and 100 square feet per bed in multi-bed rooms.

3. Each bedroom shall have a space for a wheelchair to make a 180 degree turn, which is a clear space of 60 inches in diameter.

4. Each one-bed room shall have a minimum clear floor space of 36 inches along each side of bed and 42 inches between the foot of the bed and the wall.

5. Each two-bed room shall have a minimum clear floor space of 42 inches between the foot of bed and the wall, 36 inches between the side of bed and the wall and 48 inches between beds.

6. Each four-bed room shall have a minimum clear floor space of 48 inches from the foot of the bed to the foot of the opposing bed, 36 inches between side of bed and the wall and 48 inches between beds.

7. Each patient room shall have a window.

8. A nurses' calling system shall be provided as follows:

i. Each patient room shall be served by at least one calling station for two way voice communications;

ii. Each bed shall be provided with a call button;

iii. Two call buttons serving adjacent beds may be served by one calling station;

iv. Calls shall activate a visible signal in the corridor at the patient's door; and

v. Nurses' call emergency system shall be provided at each inpatient toilet, bath, and shower room.

9. In new construction, handwashing facilities shall be provided in each patient room. In renovations and modernization, the lavatory may be omitted from the bedroom where a water closet and lavatory are provided in a toilet room designed to serve one single-bed room, or one two-bed room.

10. Each patient shall have access to a toilet room without having to enter the general corridor area. One toilet room shall serve no more than four beds and no more than two patient rooms. The toilet room shall contain a water closet and a lavatory. The lavatory may be omitted from a toilet room that serves single-bed and two-bed rooms if each such patient's room contains a lavatory.

11. Each patient shall have a wardrobe, closet, or locker with minimum clear dimensions of one foot ten inches by one foot eight inches, suitable for hanging full-length garments. An adjustable clothes rod and adjustable shelf shall be provided.

12. Visual privacy shall be provided for each patient in multi-bed rooms with cubicle curtains between beds.

(b) The services areas noted below shall be in or readily available to each nursing unit. Although identifiable spaces are required for each indicated function, consideration will be given to alternative designs that accommodate some functions without designating specific areas or rooms. Each service area may be arranged and located to serve more than one nursing unit, but at least one such service area shall be provided on each nursing floor. The following service areas shall be provided:

1. An administrative center or nurses' station;

2. A nurses' office;

3. Storage for administrative supplies;

4. Handwashing facilities located near the nurses' station and the drug distribution station. One lavatory may serve both areas;

5. Charting facilities for staff;

6. A lounge and toilet room(s) for staff;

7. Individual closets or compartments for safekeeping the personal effects of nursing personnel, located convenient to the duty station or in a central location;

8. A clean workroom or clean holding room;

9. A soiled workroom or soiled holding room;

10. A drug distribution station. Provisions shall be made for convenient and prompt 24-hour distribution of medicine to patients. Distribution may be from a medicine preparation room, a self-contained medicine dispensing unit, or through another approved system. If used, a medicine preparation room shall be under the nursing staff's visual control and contain a work counter, refrigerator, and locked storage for biologicals and drugs. A medicine dispensing unit may be located at a nurses' station, in the clean workroom, or in an alcove or other space under visual observation of nursing or pharmacy staff;

11. Clean linen storage with a separate closet or an area within the clean workroom provided for this purpose. If a closed-cart system is used, storage may be in an alcove;

12. A nourishment station, which shall contain a sink for handwashing, equipment for serving nourishment between scheduled meals, a refrigerator, storage cabinets, and icemaker-dispenser units;

13. An equipment storage room for equipment such as I.V. stands, inhalators, air mattresses, and walkers; and

14. Parking for stretchers and wheelchairs which shall be located out of the path of normal traffic.

(c) Bathtubs or showers shall be provided at a ration of one bathing facility for each eight beds not otherwise served by bathing facilities within patient rooms. Each tub or shower shall be in an individual room or privacy enclosure that provides space for the private use of bathing fixtures, for drying and dressing, and for a wheelchair and an assistant. Showers in central bathing facilities shall be at least four feet square, curb-free, and designed for use by a wheelchair patient.

(d) Patient toilet facilities shall be as follows:

1. The minimum dimensions of a room containing only a toilet shall be three feet by six feet clear space; additional space shall be provided if a lavatory is located within the same room. Toilets must be usable by wheelchair patients;

2. At least one room, other than a patient room, shall be provided for toilet transfer training. A minimum clearance of three feet shall be provided at the front and at each side of the toilet. This room shall also contain a lavatory;

3. A toilet room that does not require travel through the general corridor shall be accessible to each central bathing area;

4. Doors to toilet rooms shall have a minimum width of two feet 10 inches to admit a wheelchair. The doors shall permit access from the outside in case of an emergency and swing outward; and

5. A handwashing facility shall be provided for each water closet in each multifixture toilet room.

8:43H-24.12 Physical therapy services

(a) The following shall be provided in physical therapy services:

1. Office space;

2. Waiting space;

3. Treatment area(s);

i. For thermotherapy, diathermy, ultrasonics, respiratory therapy, hydrotherapy, and other treatments performed in a physical therapy unit, cubicle curtains around each individual treatment area shall be provided. Handwashing facility(ies) shall also be provided. One lavatory or sink may serve more than one cubicle. Facilities for collection of wet and soiled linen and other material shall be provided.

4. An exercise area;

5. Storage for clean linen, supplies, and equipment;

6. Patient toilet rooms; and

7. Wheelchair and stretcher storage.

(b) The areas designated in (a)1, 2, 5, 6 and 7 above may be planned and arranged for shared use by occupational therapy patients and staff if the functional program reflects this sharing concept.

8:43H-24.13 Occupational therapy services

(a) The following shall be provided in an occupational therapy service unit:

1. Office space;

2. Waiting space;

3. Activity areas, which shall have provisions for a sink or lavatory;

4. Storage for supplies and equipment;

5. Patient toilet rooms;

6. Space for driver evaluation; and

7. Activities for daily living.

i. An area for teaching the activities of daily living shall be provided and shall have a bedroom, bath, and kitchen space with stove accessible.

(b) The areas designated in (a)1, 2, 4, 5 and 8 above may be planned and arranged for shared use by physical therapy patients and staff, if the functional program reflects this sharing concept.

8:43H-24.14 Prosthetics and orthotics services

(a) The following shall be provided in a prosthetic and orthotic service:

1. Workspace for technician(s) and/or prosthetists and orthotists;
2. Space for evaluation and fitting which shall include provision for privacy; and
3. Space for equipment, supplies, and storage.

8:43H-24.15 Speech-language pathology and audiology services

(a) The following shall be provided in speech-language pathology and audiology services:

1. Office(s) for therapists;
2. Space for evaluation and treatment; and
3. Space for equipment and storage.

8:43H-24.16 Radiology services

(a) A radiology service shall contain the following:

1. Radiographic room(s);
2. Film processing facilities;
3. Viewing and administration area(s);
4. Film storage facilities;
5. A toilet room with handwashing facility;
6. A waiting area; and
7. A holding area for stretcher patients.

(b) A portable x-ray with film processing facilities may be used, if required by program.

8:43H-24.17 Laboratory services

(a) Laboratory services shall be provided within the rehabilitation hospital or through contract arrangement with a hospital or laboratory service for hematology, clinical chemistry, urinalysis, cytology, pathology, and bacteriology.

1. If a laboratory services are provided on-site, the following shall be the minimum provided:

i. Laboratory work counter(s) with a sink, and gas and electric service;

ii. Handwashing facilities;

iii. Storage cabinet(s) or closet(s);

iv. Specimen collection facilities. Urine collection rooms shall be equipped with a water closet and lavatory. Blood collection facilities shall have space for a chair and workcounter; and

v. Refrigerator.

8:43H-24.18 Pharmacy services

(a) Pharmacy services shall be provided within the rehabilitation hospital or through a contract.

1. If pharmacy services are provided on-site, the following shall be the minimum provided:

i. A dispensing area with handwashing facility;

ii. An area for compounding; and

iii. Locked storage areas.

8:43H-24.19 Sterilization services

Where required by the functional program, a system for sterilizing equipment and supplies shall be provided.

8:43H-24.20 Linen services

(a) If linen is to be processed on the site, the following shall be provided:

1. A laundry processing room with commercial equipment that can process seven days' laundry within a regularly scheduled workweek, with handwashing facilities;

2. A soiled linen receiving, holding, and sorting room with handwashing and cart-washing facilities;

3. Storage for laundry supplies;

4. A clean linen storage, issuing, and holding room or area; and

5. A janitor's closet, containing a floor receptor or service sink and storage space for housekeeping equipment and supplies.

(b) If linen is processed off the rehabilitation facility site, the following shall be provided:

1. A soiled linen holding room; and

2. A clean linen receiving, holding, inspection, and storage room(s).

8:43H-24.21 Housekeeping services

A janitor's closet shall be provided for each nursing unit. It may serve two nursing units if they are on the same floor and adjacent to each other. In addition, janitor's closets shall be provided throughout the facility as required to maintain a clean and sanitary environment.

8:43H-24.22 Employees facilities

Employee facilities, such as lockers, lounges, and toilets, shall be provided for employees and volunteers.

8:43H-24.23 Engineering service and equipment areas

(a) Equipment room(s) for boilers, mechanical equipment, and electrical equipment shall be provided.

(b) Storage rooms for building maintenance supplies and yard equipment shall be provided.

(c) Space and facilities shall be provided for the sanitary storage and disposal of waste. If provided, design and construction of incinerators and trash chutes shall conform to the requirements prescribed by the New Jersey Department of Environmental Protection.

8:43H-24.24 Educational services

Space shall be provided for educational services. In a pediatric unit, there shall be classroom(s) for pediatric patients as required by the New Jersey Department of Education.

8:43H-24.25 Details

(a) Compartmentation, exits, automatic extinguishing systems, and other details relating to fire prevention and fire protection in inpatient rehabilitation facilities shall comply with requirements listed in the New Jersey Uniform Construction Code, N.J.A.C. 5:23.

(b) Items such as drinking fountains, telephone booths, vending machines and portable equipment shall not restrict corridor traffic or reduce the corridor width below the required minimum.

(c) Rooms containing bathtubs, showers, and toilets, which are subject to patient use shall be equipped with doors and hardware that will permit access from the outside in an emergency. When such rooms have only one opening, the doors shall open outward or be otherwise designed to open without pressing against a patient who may have collapsed within the room.

(d) Minimum width of all doors to rooms needing access for beds shall be three feet six inches. Doors to rooms requiring access for stretchers and doors to patient toilet rooms and other rooms needing access for wheelchairs shall have a minimum width of two feet 10 inches.

(e) Doors between corridors and rooms or those leading into spaces subject to occupancy, except elevator doors, shall be swing-type. Openings to showers, baths, patient toilets, and other small wet areas not subject to fire hazard are exempt from this requirement.

(f) Doors, except those to spaces such as small closets not subject to occupancy, shall not swing into corridors in a manner that obstructs traffic flow or reduces the required corridor width.

(g) Windows shall be designed to prevent accidental falls when open, or shall be provided with security screens where deemed necessary by the functional program.

(h) Windows and outer doors that may be frequently left open shall be provided with insect screens.

(i) Patient rooms intended for occupancy shall have windows that operate without the use of tools and shall have sills not more than three feet above the floor.

(j) Doors, sidelights, borrowed light, and windows glazed to within 18 inches of the floor shall be constructed of safety glass, wired glass, or plastic glazing material that resists breaking or creates no dangerous cutting edges when broken. Similar materials shall be used in wall openings of playrooms and exercise rooms. Safety glass or plastic glazing material shall be used for shower doors and bath enclosures.

(k) Linen and refuse chutes shall comply with the New Jersey Uniform Construction Code, N.J.A.C. 5:23.

(l) Thresholds and expansion joint covers shall be flush with the floor surface, to facilitate use of wheelchairs and carts.

(m) Grab bars shall be provided at all patient toilets, bathtubs, showers, and sitz baths. The bars shall have one and one-half inches clearance to walls and shall be sufficiently anchored to sustain a concentrated load of 250 pounds. Special consideration shall be given to shower curtain rods which may be momentarily used for support.

(n) Recessed soap dishes shall be provided in showers and bathrooms.

(o) Handrails shall be provided on both sides of corridors used by patients. A clear distance of one and one-half inches shall be provided between the handrail and wall, and the top of the rail shall be 32 inches above the floor.

(p) Ends of handrails and grab bars shall be constructed to prevent snagging the clothes of patients.

(q) The location and arrangement of handwashing facilities shall permit proper use and operation. Particular care shall be given to clearance required for blade-type operating handles. Lavatories intended for use by handicapped patients shall be installed to permit wheelchairs to fit under them.

(r) Mirrors shall be arranged for use by wheelchair patients as well as by patients in a standing position.

(s) Provisions for hand drying shall be included at all handwashing facilities.

(t) Lavatories and handwashing facilities shall be securely anchored to withstand an applied vertical load of not less than 250 pounds on the front of the fixture.

(u) Radiation protection requirements of x-ray and gamma ray installations shall conform to applicable State and local laws. Provisions shall be made for testing the completed installation before use. All defects shall be corrected before the use of equipment.

(v) The minimum ceiling height shall be seven feet 10 inches, with the following exceptions:

1. Boiler rooms shall have a ceiling clearance not less than two feet six inches above the main boiler head and connecting piping.

2. Ceilings of radiographic and other rooms containing ceiling-mounted equipment, including those with ceiling-mounted surgical light fixtures, shall have sufficient height to accommodate the equipment and/or fixtures.

3. Ceilings in corridors, storage rooms, toilet rooms, and other minor rooms shall not be less than seven feet eight inches.

4. Suspended tracks, rails, and pipes located in the path of normal traffic shall not be less than six feet eight inches above the floor.

(w) Recreation rooms, exercise rooms, and similar spaces where impact noises may be generated shall not be located directly over patient bed areas unless special provisions are made to minimize such noise.

(x) Rooms containing heat-producing equipment (such as boiler or heater rooms and laundries) shall be insulated and ventilated to prevent any floor surface above and below from exceeding a temperature 10 degrees Fahrenheit (six degrees Celsius) above the ambient room temperature.

(y) Noise reduction criteria shown in Table 1 of the Guidelines for Construction and Equipment of Hospital and Medical Facilities, 1987 edition, as published by the American Institute of Architects Press, incorporated herein by reference, shall apply to partition, floor, and ceiling construction in patient areas.

8:43H-24.26 Finishes

(a) Cubicle curtains and draperies shall be noncombustible or rendered flame retardant.

(b) Floor materials shall be readily cleanable and wear resistant for the location. Floors in food preparation or assembly areas shall be water resistant. Joints in tile and similar material in such areas shall also be resistant to food acids. In all areas frequently subject to wet cleaning methods, floor materials shall not be physically affected by germicidal and cleaning solutions. Floors subject to traffic while wet, such as shower and bath areas, kitchens, and similar work areas, shall have a non-slip surface.

(c) Wall bases in kitchens, soiled workrooms and other areas that are frequently subject to wet cleaning methods shall be monolithic and coved with the floors, tightly sealed within the wall, and constructed without voids that can harbor insects.

(d) Wall finishes shall be washable and, in the proximity of plumbing fixtures, shall be smooth and moisture-resistant. Finish, trim, and floor and wall construction in dietary and food preparation areas shall be free from spaces that can harbor pests.

(e) Floor and wall areas penetrated by pipes, ducts, and conduits shall be tightly sealed to minimize entry of pests. Joints of structural elements shall be similarly sealed.

(f) Ceilings throughout shall be readily cleanable. All overhead piping and ductwork in the dietary and food preparation area shall be concealed behind a finished ceiling. Finished ceilings may be omitted in mechanical and equipment spaces, shops, general storage areas, and similar spaces, unless required for fire-resistive purposes.

(g) Acoustical ceilings shall be provided for corridors in patient areas, nurses stations, dayrooms, recreational rooms, dining areas, and waiting areas.

8:43H-24.27 (Reserved)

8:43H-24.28 (Reserved)